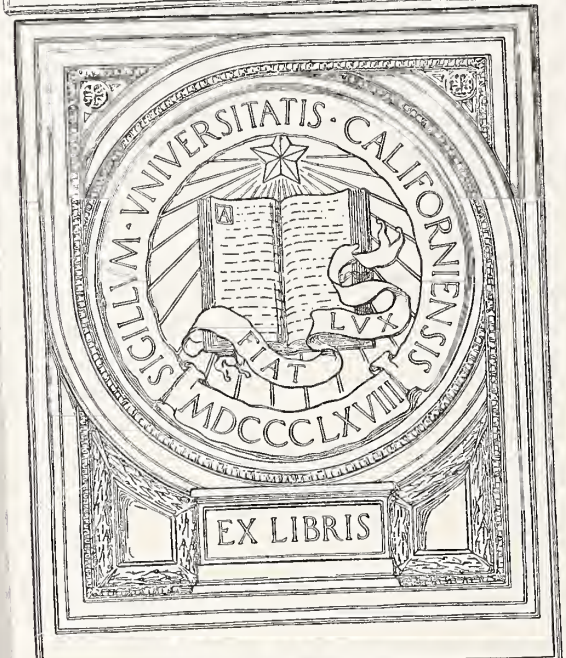
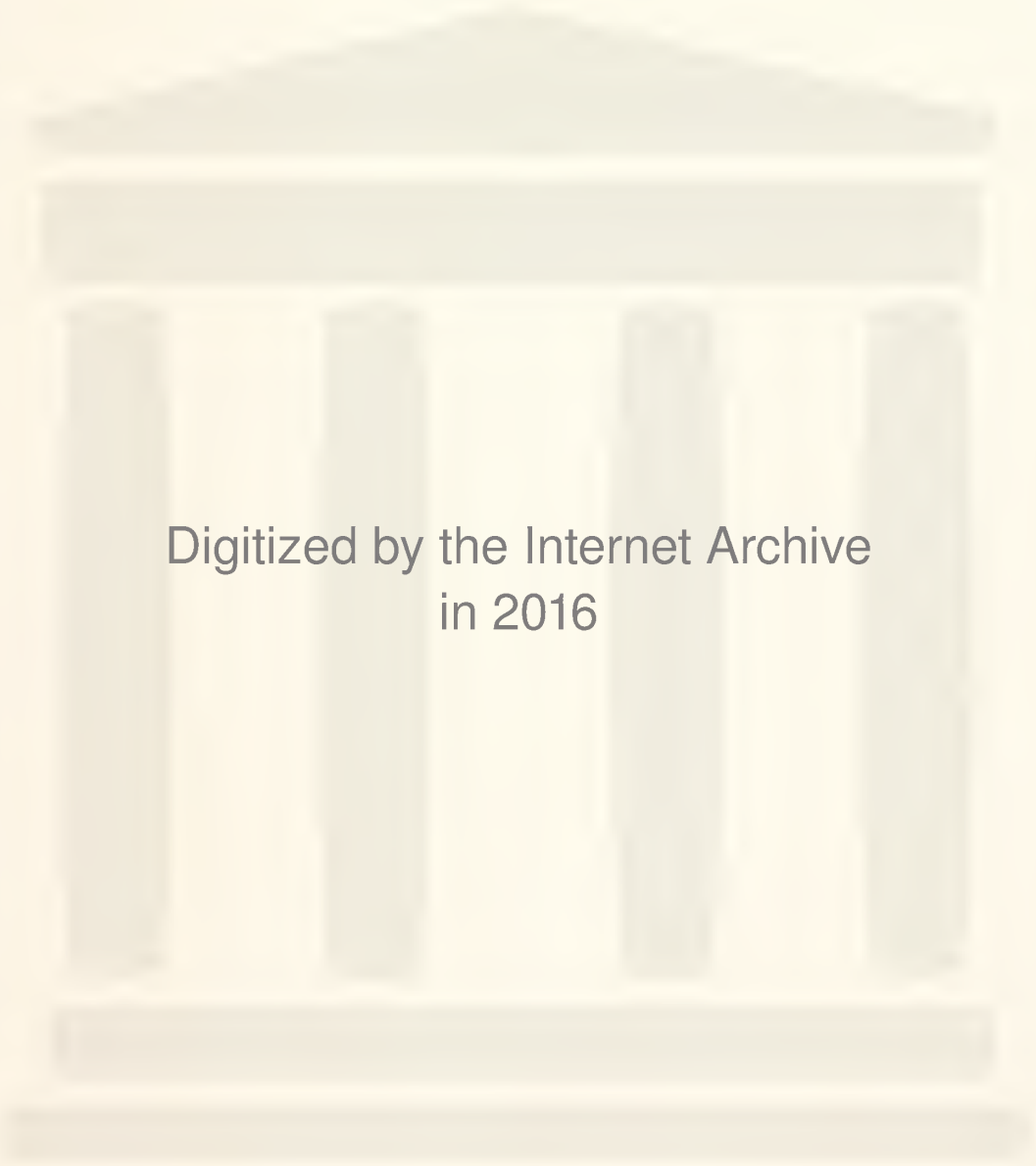
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In This Issue—

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Treatment of Insomnia with Special Reference to Valmid

Cardiac Arrhythmia Due to Use of Choral Hydrate

Economic Position of Medical Care

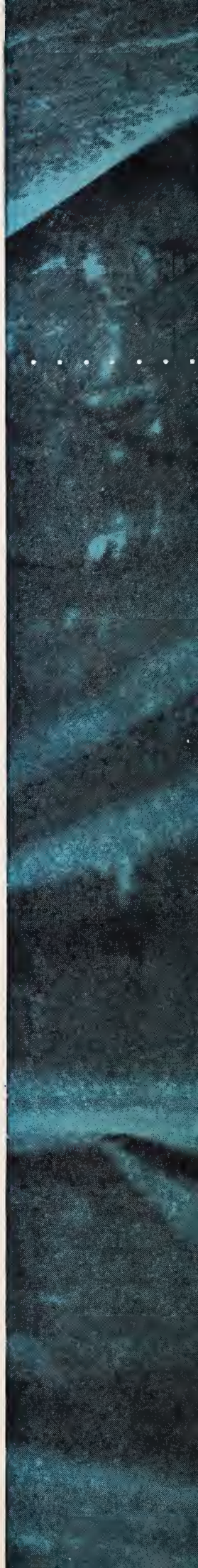
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January 1956

of the INDIANA STATE MEDICAL ASSOCIATION

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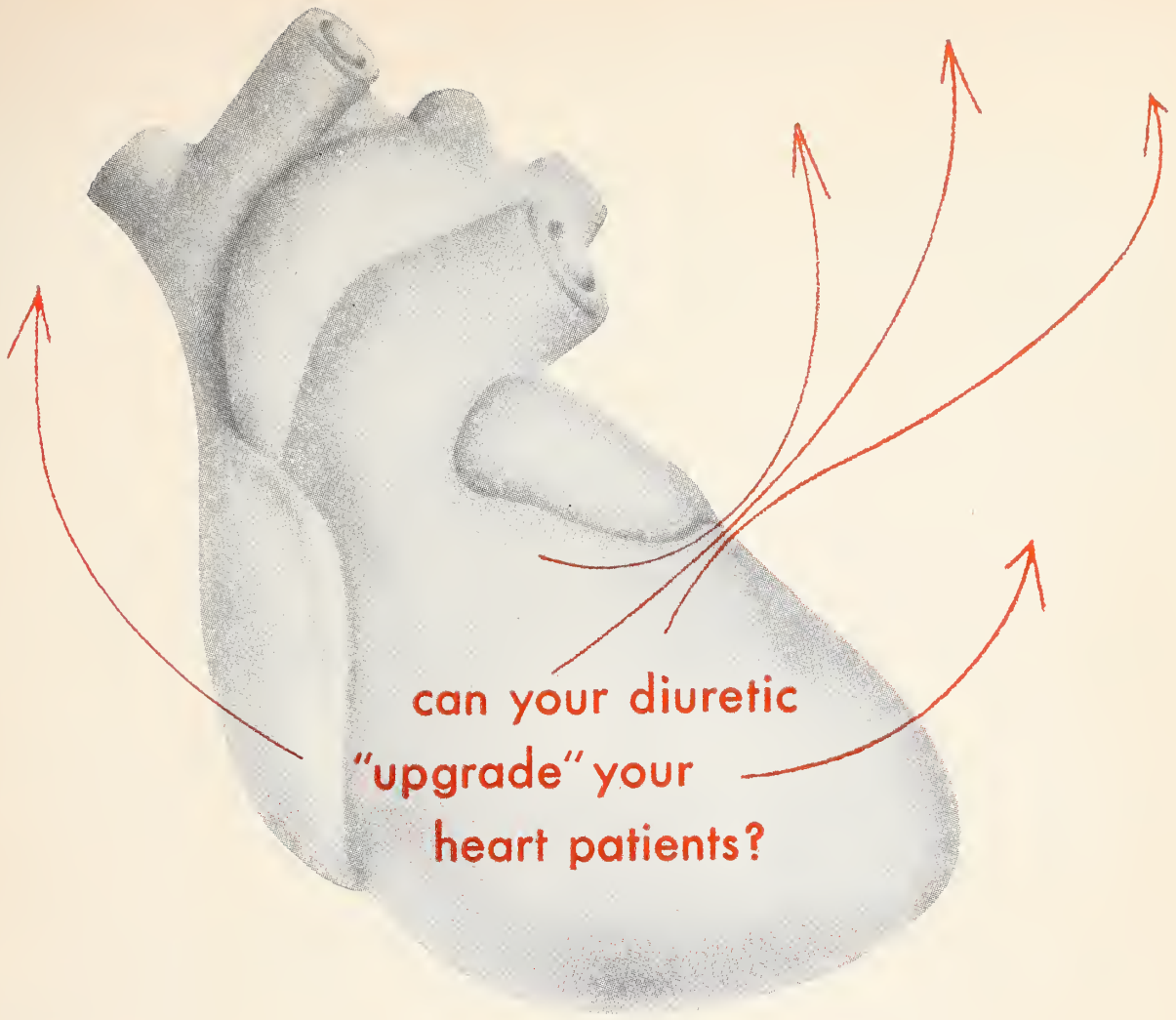
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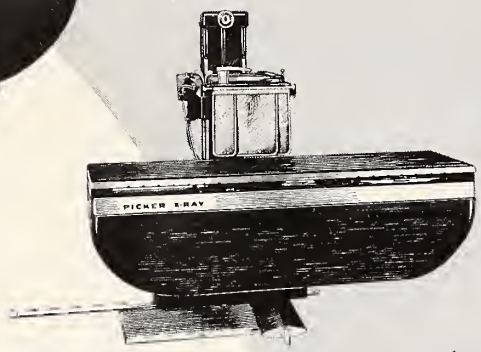
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2.	Robert H. Rang, M.D., Washington	J. S. Brown, M.D., Carlisle	Washington, 1956
3.	B. E. Sugarman, M.D., French Lick	Eli Goodman, M.D., Charlestown	
4.	J. K. Jackson, M.D., Aurora	George A. Vail, M.D., Lawrenceburg	
5.	C. M. Schauwecker, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Greencastle, May, 1956
6.	William R. Tindall, M.D., Shelbyville	H. N. Smith, M.D., Brookville	Richmond, April 19, 1956
7.	Joseph F. Ferrara, M.D., Franklin	Arthur W. Records, M.D., Franklin	Indianapolis, May, 1956
8.	Roger R. Reed, M.D., Anderson	Warren E. Fischer, M.D., Anderson	Anderson, May 9, 1956
9.	L. S. Bailey, M.D., Zionsville	Jack Porter, M.D., Lebanon	Frankfort, 1956
10.	H. M. Baitinger, M.D., Gary	S. J. Brady, M.D., Gary	
11.	T. W. Omstead, M.D., Huntington	Charles L. Wise, M.D., Camden	Delphi, May 16, 1956
12.	Jack L. Eisaman, M.D., Bluffton	A. N. Ferguson, Fort Wayne	
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Books: Received and Reviewed

BOOKS RECEIVED

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

PROLONGED AND PERPLEXING FEVERS. Chester S. Keefer, M.D., Physician-in-Chief, Massachusetts Memorial Hospitals and Professor of Medicine, Boston University School of Medicine; and Samuel E. Leard, M.D., assistant visiting physician, Massachusetts Memorial Hospitals, and Instructor in Medicine, Boston University School of Medicine. 246 pp. Price $5.50. Little, Brown & Company, Boston 6, Mass. 1955.

PHYSICAL SIGNS IN CLINICAL SURGERY. Hamilton Bailey, F.R.C.S. (Eng.), F.A.C.S., F.R.S.E., Emeritus Surgeon, Royal Northern Hospital, London, General Surgeon, Metropolitan Ear, Nose and Throat Hospital; and Allan Clain, M.B., Royal Cancer Hospital, London. 12th ed., 456 pp., illustrated in color. Price not listed. The Williams & Wilkins Company, Baltimore 2, Md. 1954.

HYPOTENSION: SHOCK AND CARDIOCIRCULATORY FAILURE. Paul G. Weil, M.D., Director of Transfusion Service, Royal Victoria Hospital, Montreal, Canada. 78 pp., illustrated. Price $2.25. J. B. Lippincott Company, East Washington Square, Philadelphia 5, Pa. 1955.

AGEING—GENERAL ASPECTS. Vol. I. Ciba Foundation. Colloquia on Ageing. 255 pp., illustrated. Price $6.75. Little, Brown & Company, 34 Beacon Street, Boston 6, Mass. 1955.

THE MEDICAL SIGNIFICANCE OF ANXIETY. Richard L. Jenkins, M.D., Chief, Psychiatric Research, Psychiatry and Neurology Service, Veterans Administration, Washington 25, D.C. 46 pp. pamphlet. Price $1.00. The Biological Sciences Foundation, Ltd., Washington 7, D.C. 1955.

TEA—A Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea. Henry J. Klaunberg, editor. 64 pp., illustrated. Price $1.00. The Biological Sciences Fondation, Ltd., Washington 7, D.C. 1955.

THE BEHAVIOR OF PULMONARY TUBERCULOUS LESIONS: A Pathological Study. E. M. Medlar, M.D., Chief Pathologist, Division of Tuberculosis, New York State Department of Health, Herman M. Biggs Memorial Hospital, Ithica, New York, Lecturer in Pathology, Columbia University. 244 pp., illustrated in color. Compliments of the Hegeman Fund, by F. H. Ecker, Honorary Chairman of the Board, Metropolitan Life Insurance Company, 1 Madison Avenue, New York, N. Y. 1954.

THE HUMAN ADRENAL CORTEX. Vol. VIII, Ciba Foundation Colloquia on Endocrinology. 665 pp. with 227 illustrations. Price $10.00. Little, Brown and Company, 34 Beacon Street, Boston, Mass. 1955.

SEXUAL HYGIENE AND PATHOLOGY: A Manual for the Physician. John F. Oliven, M.D., Psychi-



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Books Received (Continued)

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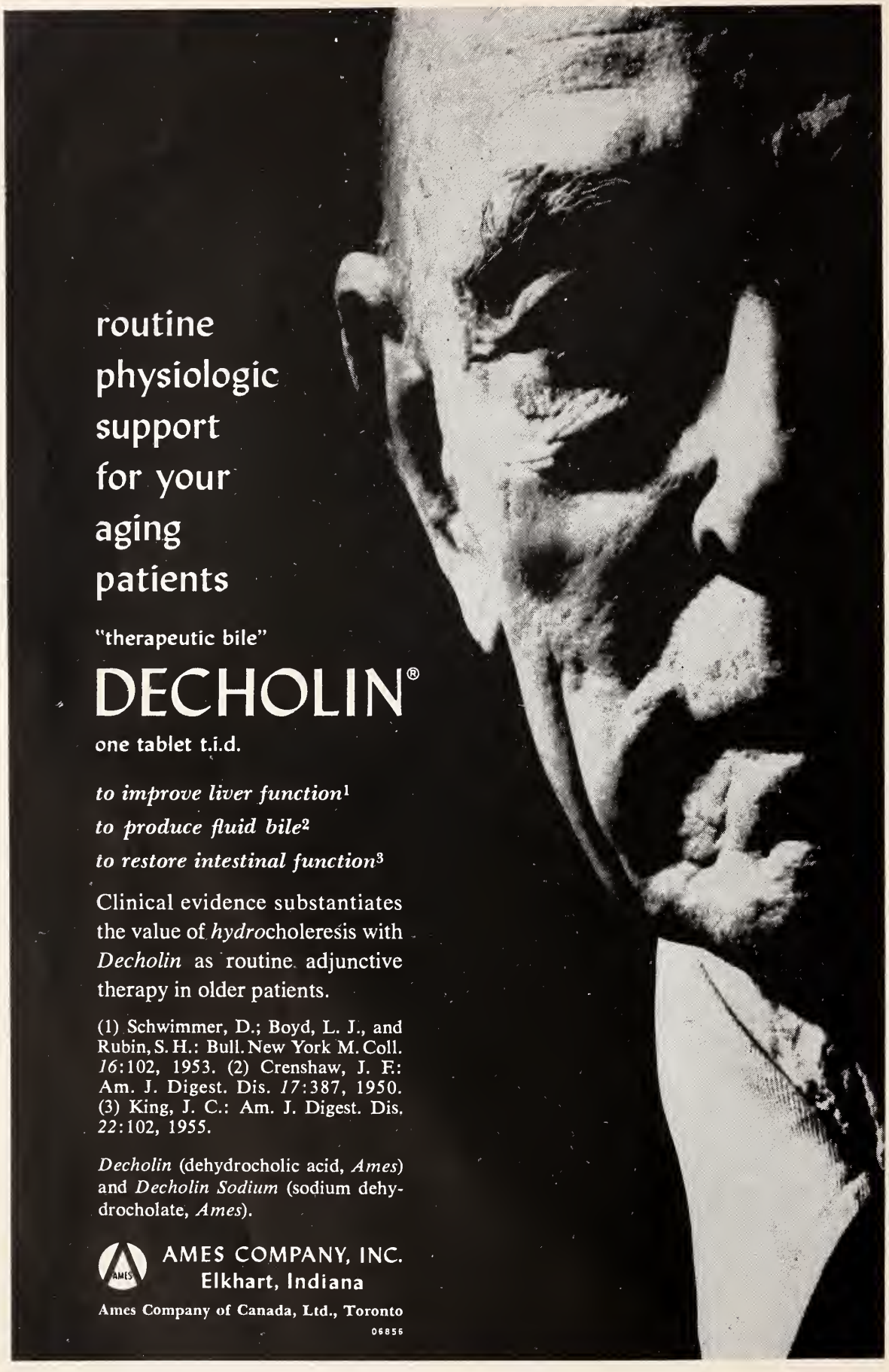
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(1) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953. (2) Crenshaw, J. F.: Am. J. Digest. Dis. *17*:387, 1950. (3) King, J. C.: Am. J. Digest. Dis. *22*:102, 1955.
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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C.—The second session of the eighty-fourth Congress is under way, and in medical legislation—as in all other fields—this promises to be much livelier than last year's deliberations.

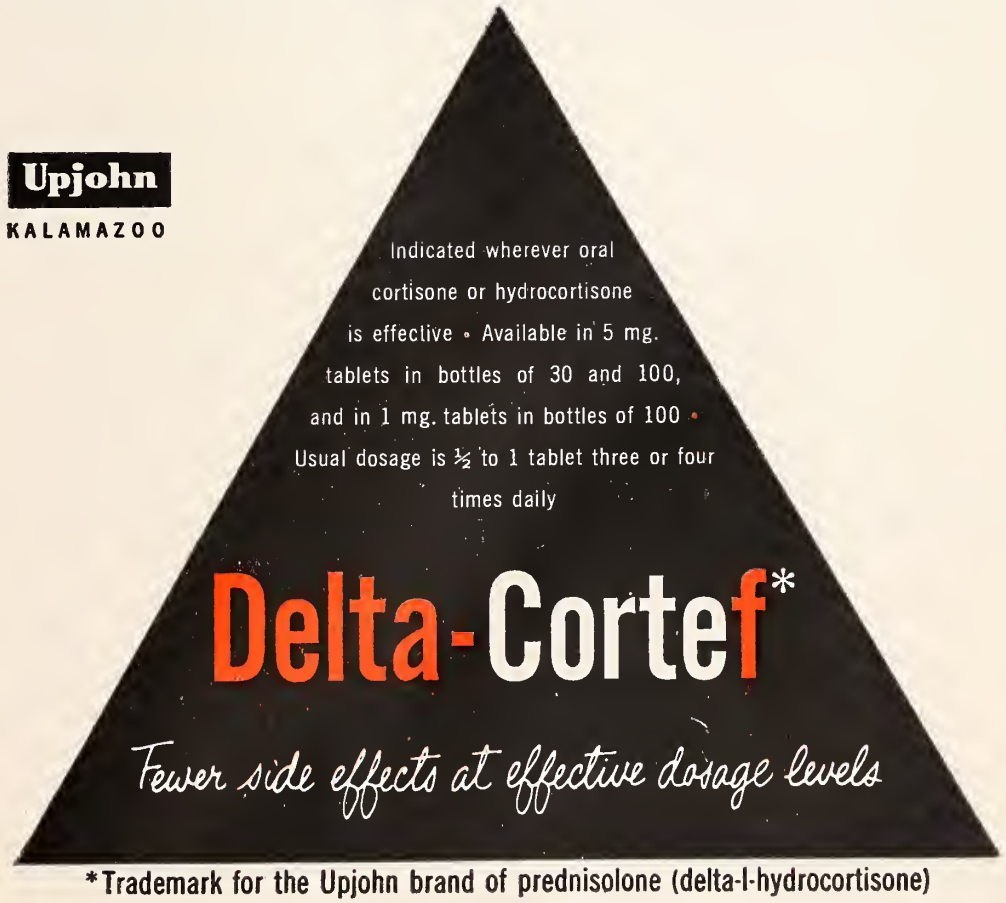
For one thing, neither the Republican administration nor the Democratic party, which is in control on Capitol Hill, got anywhere near as much as it wanted last year in medical legislation.

For another thing, and something that shouldn't be lost sight of at any time, both parties this year will be legislating with one eye cocked toward next November, when the voters make a choice between the two parties. Try as they might to pass laws for the good of all the people, neither party can afford to ignore the political realities of the situation: each will want to take credit for any legislation with popular appeal or where that is impossible, at least to see that the other party doesn't get the credit.

PLANS BLOSSOM AGAIN

In front of this political mosaic, these are some of the medically-important issues that will be fought out in Senate and House:

1. Federal guarantee of mortgages on health facilities. This has been on the Congressional



calendar for two years; it was pushed hard in 1954, and was given some consideration in 1955. It would mean that the federal government would underwrite mortgages for hospitals, clinics and nursing homes, under certain conditions, thereby allowing some sponsors to obtain loans they otherwise couldn't get, or to obtain them on longer terms and with lower interest.

2. Federal grants for research facilities. Under this plan—approved last session by the Senate—the U. S. would make outright grants to laboratories, medical schools and clinics for building facilities for research in specific diseases, such as cancer and heart disease.

3. Federal aid to medical education. This perennial project probably is closer to Congressional enactment now than ever before. The most popular bill is one restricting the federal role to grants for building and equipment, with a financial incentive held out to those schools willing to increase their enrollment. This bill may be tied in with some other grants bill, such as the one for research.

U. S. CONTROL?

4. Salk vaccine. Legislation authorizing federal appropriations for the purchase of Salk poliomyelitis vaccine ($30 million for the current year) expires February 15, virtually insuring Congressional action of some sort before that date. One issue is whether the federal government should continue the grants; more controversial is the question of whether the U. S. should move in to control the allocation and distribution of the vaccine. Allocation and distribution now are handled under a voluntary program supervised by the U. S. Public Health Service.

5. Increases in federal appropriations for medical research. Over the last few years—since the National Institutes of Health came of age—Congress repeatedly has increased research grants over the amounts the Budget Bureau allowed Public Health Service to request. Indications are that this year the Budget Bureau may have to give way and allow important increases to be requested of Congress. Congress probably would want to add on its own special additions anyway, resulting in more money than ever before available for work on cancer, heart disease, mental illness, arthritis, blindness and the many other conditions.

Re: H.R. 7225

6. OASI-covered persons could receive payments beginning at age 50 if determined to be disabled. Under present law, retirement payments for all are available at age 65. The bill containing this provision (H.R. 7225) passed the House last session by an overwhelming margin. It is now before the Senate Finance Committee, where the next phase of the legislative contest will be fought out in 1956.

The lopsided House vote on disability payments may be discounted in part because of the parliamentary maneuvering by sponsors of the legislation. House members had only 40 minutes to debate this bill, and no opportunity to amend it. It was a case of accepting the whole bill—which contains a number of other social security liberalizations not of medical significance—or being politically damned as opposed to social security per se.

The American Medical Association maintains that the present expanding rehabilitation programs would be undermined by cash payments for disability, that the financial and other long-range aspects of the disability payments plan have not been thoroughly studied, and that the machinery for disability payments would inevitably project the federal government deeply into the medical care picture.



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1. Howell, T.H.; Harth, J.A.P. and Dietrich, M.: Practitioner *173*:172.
*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

Letters to Editor:

FRANK E. WIEDEMANN, M.D.
Rose Dispensary Bldg.
Terre Haute, Indiana

November 21, 1955

Journal of the Indiana State
Medical Association
Indianapolis, Indiana

Gentlemen:

I was much interested in your Editorial on Automobile Safety.

It is no wonder that we physicians are up in arms because of so many needless fatalities and injuries due to automobile travel.

In the last 20 years more than 700,000 persons have been killed and many more received serious injuries in auto driving.

Statistics show that in the last 50 years more people have been killed in auto accidents than have been killed in all the wars in the United States put together. In 1953 there were 2,000 deaths from poliomyelitis, whereas auto fatalities accounted for 38,000.

These facts are sufficient to stir the indignation of the public—and something should be done to place them before the citizens—demanding some correction.

We all know that auto accidents occur because of many things—inferior construction, incompetent operators, emotional unbalance and stress, tardy reaction in emergency, especially in teenagers, and speed maniacs. ALSO this terrific speed that is spreading throughout the states, causing much stress and emotionalism among our people.

What is the solution? I think safety devices are very important, likewise speed laws, driving instructions, and mechanical perfection, but with all of this, place a neurotic or an emotional teenager back of a wheel and give him a high powered machine—the public had better look out for their safety.

To my way of thinking the GREAT prevention is comparatively simple but requires "guts".

It is up to the Government. It should step in and not allow automobile manufacturers to make cars to go faster than 60 to 65 miles per hour. It is true the manufacturers would rise up in arms—for reasons that are not difficult to see—but life is more important than salesmanship. Such an act would save many, many lives, fewer cripples would be seen and (think of this) it would have a tendency in subduing and overcoming some of our stress and emotionalism among our American people.

Very truly yours,

Frank E. Wiedemann, M.D.



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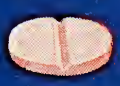
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The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

GOOD TIME TO CHECK UP

Diabetes, which still ranks eighth in the list of causes of death by disease, is a chronic condition which develops when the body can't use some of the food you eat, especially sugars and starches. Diabetes can be fatal unless properly treated.

It is estimated that there are more than two million diabetics in the United States, and half of that number are unaware they have the ailment. In other words, one person in every 75 in this country is a diabetic.

Approximately three million other persons living today are potential diabetics, which means that they will develop the disease sometime during their lives. At least 60,000 persons become diabetics each year.

Diabetes is hereditary. Of the total U. S. population, 40 million persons—or one out of every four persons—are believed to be diabetic "carriers." "Carriers" of diabetes are persons who are free of the condition themselves but who transmit the tendency to it.

Diabetes is a disease of complications. the most serious of which may be heart disease, failing eyesight, hardening of the arteries, kidney disorders, gangrene, cerebral hemorrhage, or diabetic coma.

Usual symptoms are increase in thirst, constant hunger, frequent urination, loss of weight, intense itching, easy tiring, pain in fingers and toes, changes in vision, and slow healing of cuts and bruises. However, diabetes may be present without any symptoms at all.

The most likely targets are persons who are overweight, past 40, or related to diabetics. For a woman after 40 the chances of becoming a diabetic are about one-third higher than for a man.

Diabetes can strike anyone at any time. Cases are known of the disorder in a nine-day-old boy and in a 99-year-old woman.

Diabetes can be controlled by diet, exercise, and, when necessary, by insulin.

The Diabetes Detection Drive this week is conducted by the American Diabetes Association in cooperation with its 39 affiliate units throughout the United States and with more than 900 county and state medical societies. During Diabetes Week, detection tests are provided by Kokomo physicians without charge.

The goal is to find as many as possible of the one million undetected diabetic men, women and children. Discovered early, and with proper medical treatment, a diabetic may live a practically normal life. It's a good time for you to check up.

—**Kokomo Tribune**

November 14, 1955.

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Books Reviewed

MANAGEMENT OF ADDICTIONS. Edited by Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, New York. Philosophical Library, New York. 1955.

This excellent book, which deals with the treatment of alcoholism and the addiction to drugs, is divided into two parts, the various chapters being written by authorities in the treatment of these disturbances. The book discusses all recognized therapies, contributors numbering over 40 individuals well known in the fields of medicine and nutrition.

The first part, which consists of 26 chapters, is devoted entirely to the treatment of alcoholism. Psychodynamics, the use of psychotherapy, the use of adrenosteroids, the use of endocrines and the use of the nutritional approaches are discussed in detail. Further chapters discuss treatment utilizing various drugs, such as Mebaral, calcium, dimenthylane and Tolserol. The aversion treatment of alcoholism, as well as the condition reflex treatment with and without the use of intravenous pentothal, is discussed as well. A final chapter on the alcoholic problem in general is also included in the first part of the book.

The second part is devoted primarily to the treatment of drug addiction, nine chapters being devoted to this subject. The use of group phychotherapy in the narcotic addict is discussed as well as the use of the adrenocortical extracts. An excellent chapter outlining the results of the hospital treatment of 75 patients, is also included in this particular part of the text. In this group, 36 per cent of the individuals benefited when placed on a hospital program similar to that provided for patients who suffered from psychiatric disorders of functional types. The use of prolonged sleep, as well as the use of injectable benadryl, as a valuable adjunct in the treatment of the withdrawal syndrome, is described in detail. A preliminary report on the use of electric convulsive therapy in the addictions is also presented.

All in all, the volume is an excellent one as the mechanisms of addiction are thoroughly explored and methods of therapy are presented in a detailed form. This book is, of course, primarily intended for physicians, but it will also prove of interest to others in allied fields who are interested in the problem of addictions.

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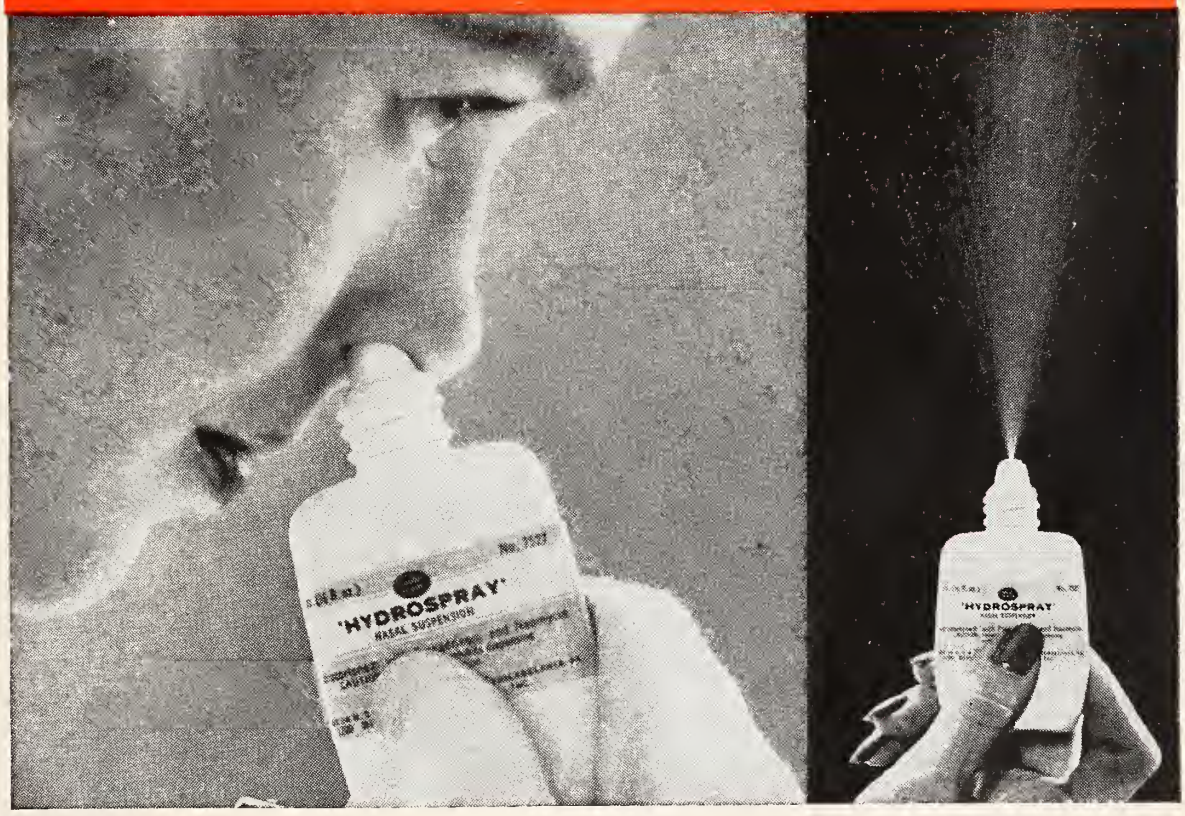
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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* **60**:431, Oct. 1954.

Problems of Medical Education on Chicago Congress Agenda in February

THE ROLE OF ADVANCED TRAINING in the over-all medical education picture will be discussed during the opening session of the 52nd annual Congress on Medical Education and Licensure to be held February 11-14 at the Palmer House, Chicago. The meeting will be sponsored by the AMA's Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

Special attention will be paid to current problems in residency training such as the basic science content of a residency program, the organization and administration of a residency program and the psychiatric viewpoint in training residents during the all-day sessions on Saturday, February 11. An open meeting of the Advisory Board for Medical Specialties will be held Sunday morning with an open meeting of the Federation of State Medical Boards in the afternoon. Monday's sessions will be devoted to discussions of trends in specialization, problems relating to clinical faculty appointments and the private practice of medicine, and new approaches in medical education. The February 14 program will be conducted by the Federation.

More than 500 medical educators, officers and members of state licensing boards and others interested in medical education are expected to attend the four-day conference.

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Pork in the Human Dietary

PORK MAY be looked upon as an important factor in America's general health and well-being. The average intake of pork in America is about 46 pounds of lean pork and 20 pounds of bacon and salt pork per person each year.[1] But America's demand for pork goes further than taste appeal and deeper than mere statistics. Pork makes a valuable contribution to day-in-and-day-out nutrition.

Pork rates among the foremost sources of thiamine. As a source of all other B vitamins and many essential minerals, such as iron and phosphorus, pork meat is considered an important dietary constituent.

Lean pork is virtually completely digestible. Its protein serves to promote growth and aid in the maintenance of tissue cells. Like all high quality protein, that of pork aids in the elaboration of protein hormones, enzymes, and antibodies.

Pork constitutes a valuable part of the daily diet (Table I), and also contributes importantly to the nutrition of the pregnant woman (Table II).

Pork and pork products have won America's favor by their unique combination of economy, palatability, and nutritional value.

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Cooked Pork Chops, Ham, and Pork Sausage
Nutrients and Calories Provided by 3-Ounce Portions

TABLE I	Protein Gm.	Thiamine mg.	Niacin mg.	Riboflavin mg.	Iron mg.	Phosphorus mg.	Calories
Pork Chops, without bone, cooked, 3 oz.[2]	20	0.71	4.3	0.20	2.6	200	284
Ham, without bone, cooked, 3 oz.[2]	20	0.45	4.0	0.20	2.6	202	338
Pork Sausage, cooked, 3 oz.[3]	14	0.42	2.8	0.20	2.1	139	396

3.5 ounces of fresh pork loin, equivalent to approximately 3 ounces of cooked loin, contains 0.47 mg. pantothenic acid;[4] 0.10 mg. pyridoxine;[4] 0.005 mg. biotin;[5] 36 mg. inositol;[4] 0.08 mg. folic acid;[4] 0.0027 mg. vitamin B_{12};[6] 63 mg. chlorine;[7] 0.1 mg. copper;[7] 20 mg. magnesium;[7] 280 mg. potassium;[7] 70 mg. sodium;[7] and 0.01 mg. manganese.[7]

Nutrients and Calories of Cooked Pork Chops (3 ounces) Expressed as Percentages of Recommended Daily Dietary Allowances[8]

TABLE II Percentages of Allowances for:	Protein	Thiamine	Niacin	Riboflavin	Iron	Phosphorus	Calories
Girls, 13-15 years of age; weight, 108 lb.; height, 63 inches.	25%	55%	33%	10%	17%	15%	11%
Women, 25 years of age; weight, 121 lb.; height, 62 inches.	31%	59%	36%	14%	22%	17%	12%
Pregnant Women (3rd trimester)	25%	47%	29%	10%	17%	13%	11%

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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Ford Hospital Medical Society Issues Invitation

Members of the medical profession are invited to attend the monthly meetings of the Henry Ford Hospital Medical Society. Meetings are held in the hospital auditorium at 8:15 p.m. On January 17, 1956 Dr. Jonathan E. Rhoads, University of Pennsylvania, will discuss "Preventive Surgery: Gains versus Losses". February 14 meeting will be devoted to a paper by Dr. Marion A. Blankenhorn, University of Cincinnati, on "Diagnosis and Treatment of Disseminated Miliary Diseases of the Lungs". Dr. Henry K. Beecher, Harvard Medical School, will discuss "New Work on Pain" on March 13. The Roy D. McClure Memorial Lecture will be given on May 15 by Dr. Evarts Graham, Washington University School of Medicine, on the subject: "How good is the Evidence for an Etiological Relationship Between Cigarette Smoking and Cancer of the Lung?". Dr. A. McGehee Harvey, Johns Hopkins University, will talk on June 19 on "Observations on the Clinical Course of Systemic Lupus Erythematosus".

ANNUAL CLINICAL CONFERENCE

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One-Man Hospital Receives Joint Commission Accreditation

EVERY YEAR the Joint Commission on Accreditation of Hospitals surveys 1,500 hospitals, and over a three-year period it surveys 4,000 institutions. Not until recently has it ever approved a hospital directed and operated by only one physician.

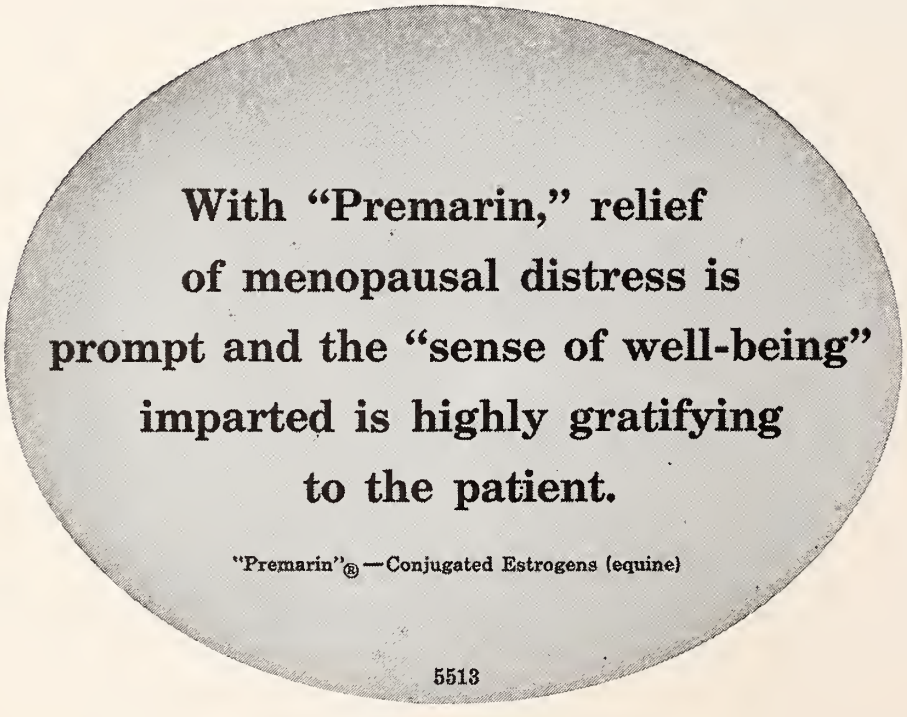
The Maynard MacDougall Memorial Hospital in Nome, Alaska, a 25-bed institution, was given full accreditation by the Joint Commission recently. The hospital is run by the Women's Division of Christian Service of the Board of Missions of the Methodist Church and its medical director and only physician on the staff is Dr. Fred M. Langsan, a general practitioner.

"The hospital," said Dr. Kenneth B. Babcock, commission director, "was surveyed and found to be in excellent maintenance and condition, and clean and sanitary throughout, with a cheerful, friendly atmosphere pervading the entire institution."

Dr. Langsan often holds consultations with members of a U. S. Air Force hospital which is located nearby. Staff people of the Air Force hospital have flown into Nome to be of assistance at specific times. All x-rays and pathological tissues are sent to Seattle and the reports are sent back air mail.

In his report, the commission's surveyor said that "the charts containing histories, physicals, and laboratory reports are excellent, and would do credit to any teaching hospital."

Commenting on the fact that this is the first one-man hospital ever accredited by the commission, Dr. Babcock said "it's a wonderful example of a fine job being done by a dedicated general practitioner."



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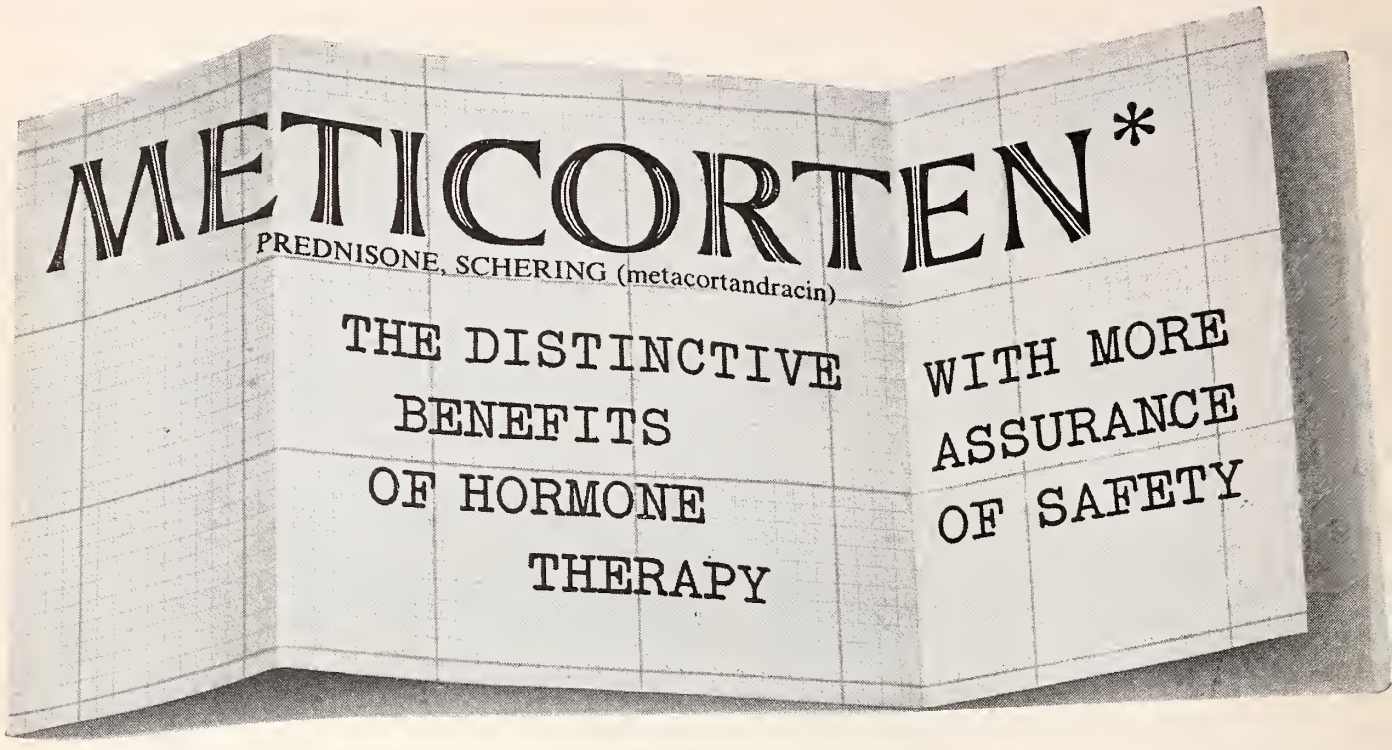
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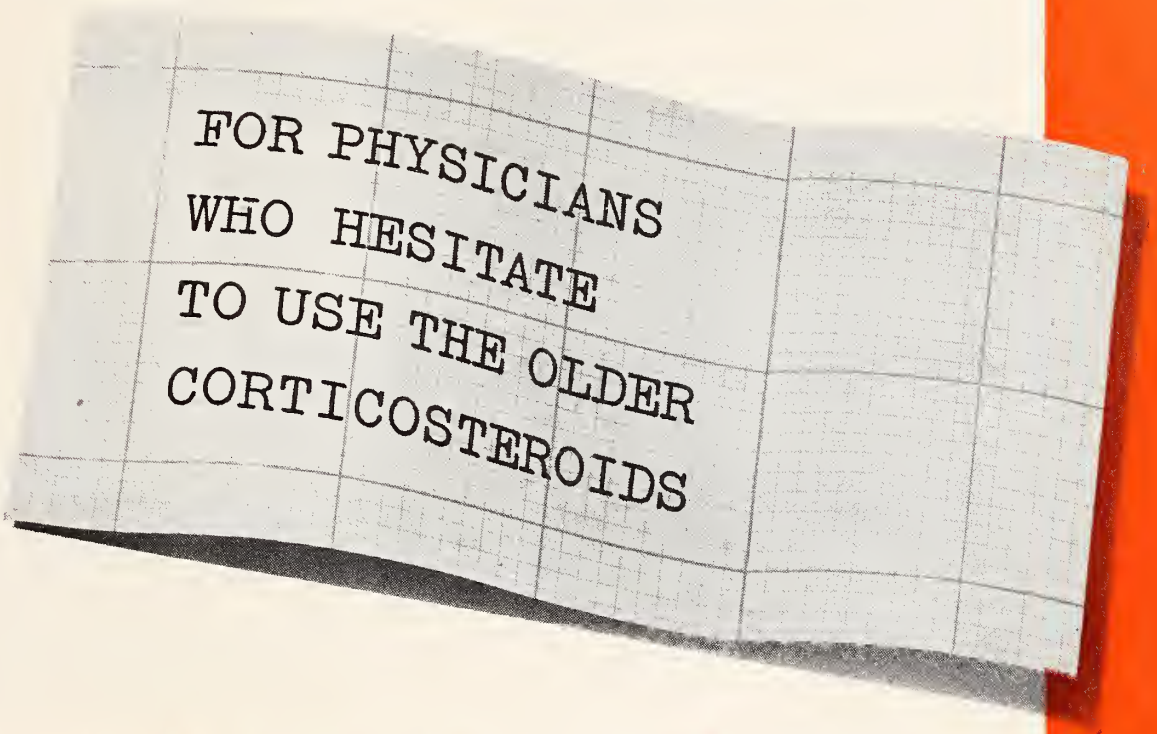
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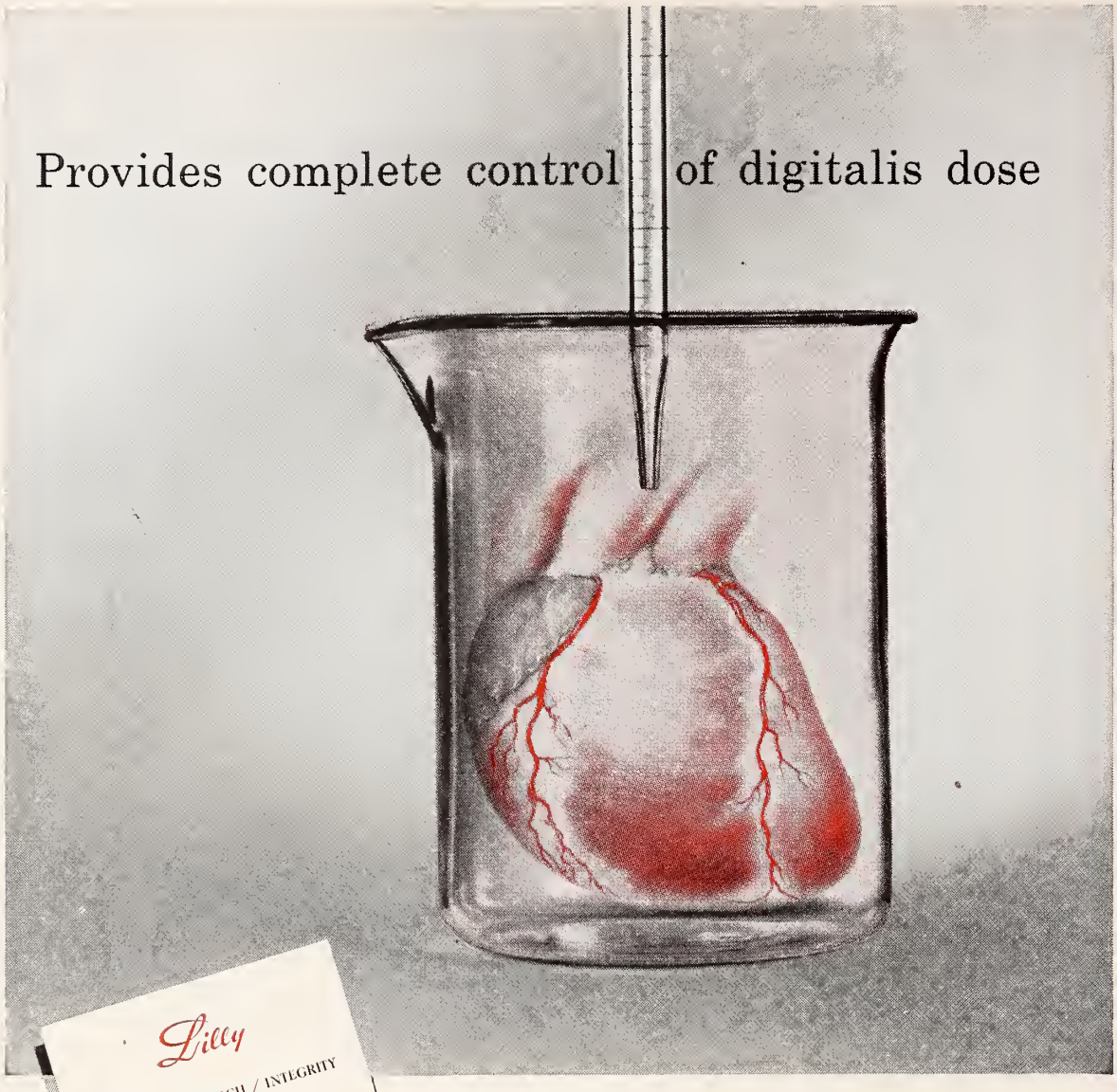
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

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The Importance of the Emotional Aspects of Early Childhood*†

COMMANDER ROBERT E. SWITZER (MC)
COMMANDER JAMES N. SUSSEX (MC)
United States Navy

NORMAL CHILDHOOD emotionality must have its beginning at birth. There are those who believe that external emotional factors make an imprint upon an infant's personality even in the prenatal period. For our purposes we may say that the child comes into the world with his physical constitution predetermined and armed with a host of instinctive urges which energize his drive toward maturity. He emerges from his solitude into a world of interpersonal relationships and the emotional atmosphere that surrounds them. It is his perception and interpretation of and his response to these relationships that will make for his emotional individuality. It has often been said that the common denominator of all psychiatric illness is disordered interpersonal relationships. Therein lies the reason for the importance of the interpersonal relationships of childhood, particularly the early relationships.

An infant needs to be born into an atmosphere of acceptance, love and approval in order that he may experience security and maximum freedom from anxiety from the very beginning. Efforts toward that end are seen in the trend in recent years toward "rooming in", that is having the baby stay with the mother during the period of hospitalization after delivery. This gets away from the idea of the "little stranger" who comes to visit and gives these two people a chance to get acquainted during the leisure of the mother's convalescence. And, of course, who is better equipped than the mother to give the new baby the acceptance, love and approval that he needs? The infant needs, also, from the very beginning,

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† The opinions or assertions contained herein are those of the authors and are not to be considered as official or reflecting the views of the Navy Department or the naval service at large.

to be recognized and respected as an individual by all who come in contact with him. He may be very much like any other baby but he is also an individual different from all other babies ever born.

One might ask, "How can you respect the individuality of a new-born baby?" The answer is, I think, to allow him to make the decisions that he has the capacity to make and to provide consistent guidance when he does not have the capacity. In that answer lies the dilemma which makes being a parent the most difficult as well as the most important job in the world. A parent must be one who can be loving, giving and allowing on the one hand and who can fairly consistently restrict, disallow, make decisions and say "no" on the other.

The first question might be followed by another—"What decision can a new-born child make?" At first an infant is completely dependent and helpless. He only takes and gives nothing in return. But in his taking he is relating. He relates by taking in through his physical sensations. He also takes in through his mouth. The latter is his major way of relating in the beginning and because that is true his early eating experiences should be as comfortable and free from anxiety as possible because they are so intimately tied up with his first interpersonal relationships. This connection between eating and relating also provides one of the answers to the second question. The infant can decide when he is hungry and he can decide when his hunger is satisfied. Allowing this expression of individuality and preventing discomfort and anxiety related to eating and to the relationship with mother is of greatest importance and is reflected in the "demand feeding" of recent years. That is, the infant becomes hungry, makes his wishes known and is fed without particular regard for the clock or the amount of intake. Another decision that the infant can make which is closely related to the eating schedule that he sets up for himself is that of deciding when he wants to sleep and be awake.

Comfortable and free from anxiety in the modes of relating at his disposal, the infant develops physically and new methods of relating become available. Auditory and visual acuity improve, the world around him expands to include the entire family and is taken in and related to. Muscular activity improves and is indulged in pleasurably. New foods are added on the basis of his decisions as to whether he likes them or not. He learns to relate in a returning, giving way through emotional response, facial expression, throaty sounds and muscular activity. Hand-eye coordination, sitting up, crawling and walking make for an ever increasing circle of give-and-take interpersonal relationships.

CULTURAL DEMANDS

Along in this stage of development comes the first culturally determined limitation on the child. He must stop sucking! He must give up the bottle or breast. There is no logical reason why he should, but he must if he wants continued acceptance and approval. However, a particular child is different from all others and we may expect that his sucking needs whether instinctive or learned may be lesser or greater than those of some other child. Greater importance lies with his participation in the decision to stop and in the process of stopping than in the abruptness or rapidity with which it is accomplished.

With walking, talking and greater physical capacity comes the period of skill development and concrete learning. The infant has become a child with a rapidly developing personality all his own. He explores and learns to cope with his immediate environment and energetically strives to enlarge the boundaries of his world. It is this blossoming from a helpless and completely dependent infant to a walking, running, climbing, jumping, exploring, investigating, experimenting child with boundless energy and unlimited curiosity which again emphasizes the dilemma of a parent. Parents must at the same time be loving, giving and allowing and the ones who fairly and consistently disallow, make decisions and say "no". When all of the above qualities enter in healthy proportions into the attitude of parents toward the child, his energies are channeled into further comfortable emotional and intellectual growth within the framework of socially acceptable behavior. If the attitude of the parents is strongly weighed in one direction or the other or is inconsistent, then the child's drive toward emotional growth may in part be frustrated and great stores of feeling and emotional energy may be pushed down into the unconscious or converted into neurotic symptoms or unacceptable behavior.

A second great cultural demand is made on the child during the period of skill development. He must learn to put the content of his bowel and bladder in a particular place, in a specified manner and often at a specified time. This is a blow to his individuality, but when the demand is made in the face of a good parent-child relationship, then the physical capacity to meet the demand, the need to conform, the desire for continued approval and some power of communication whereby he can enlist technical assistance as he learns the process, will carry him through to self-training rather than to "being broken". As in all of the frustrations and limitations imposed upon the child's freedom by the growing-up process, optimum toilet training should be done as comfortably as possible so that in the end the necessary restrictions are accomplished but with a minimal adverse emotional reaction which might bring about a great deal of repression, symptom formation or unhealthy attitudes toward others. At best this early growing-up process is a difficult time for the child to the extent that in later years he has little conscious memory of this period.

His increased skill, capacity and self-assurance lead the child into greater socialization. He asks a thousand questions, notes likenesses and differences and accumulates a great mass of factual material. He gradually moves from solitary play to group play. Each new experience and impression gives him background on which to react to new situations. Each new day brings additional skill and knowledge.

THE "I" AND "ME" PHASE

Participation in activity with other children sharpens the child's focus on himself, his identity, his property and his rights. Because of the lack of experience in this area he bolsters his concept of "I" and "me" by identifying with the parent of the same sex and by adopting many traits of that parent in order to have a more specific self-awareness. This identification may be so strong that the child shows evidence of trying to assume the role of the parent of the same sex and wishing to take the parent of the opposite sex for his own. Involved in this activity are the beginnings of awareness of sexuality, the differences in sex and the pleasurable potential of his own genitalia. The natural conflicts of this period in terms of fear of loss of love and fear of punishment and retaliation, are solved through increased efforts toward definition of the self. Added emphasis is placed on this definition by entry into school or pre-school where the child experiences continued close relationships with his contemporaries away from the home, yet under the supervision of a parent substitute. The school situation puts emphasis on individual achievement within the framework of the group. The push toward a great deal of learning and, toward group as well as individual achievement, along with his ever-present need for acceptance and approval, helps him put aside his sexual drives until he has more nearly accomplished emotional and physical maturity. Throughout his expanding interpersonal relationships the growing child continues to make identifications and to take into himself attributes of others as well as the rules by which the emulated individuals live. In this way he develops the capacity to place restrictions on himself and increases his ability to stand as a responsible individual.

EMOTIONAL MATURATION

The long process of emotional maturation builds upon itself from the very beginning and continues through the long years of intellectual and physical growth; through the normal conflicts of re-awakened sexuality in adolescence and the later ambivalence of assuming full adult responsibility—on the normal adult emotionality, which can be described as including:

—freedom from disabling conflicts and emotionally determined symptoms.

—the capacity to make a satisfying work adjustment.

—the ability to love someone other than one's self.

All of these qualities have their beginnings in normal childhood emotionality.

One is impressed by the naturalness and simplicity of this process by which a personality unfolds and takes on ever-new meanings in terms of its own increased capacities for relating to its environment and the people in it. In spite of its simplicity, however, unhappily there are many pitfalls along the way, many stumbling blocks on which the child can stub his toe, many times when his own limited experience and lack

of a consistent framework provided by his parents combine to produce various departures from and distortions of what we have seen to be the simple, natural way of growing emotionally.

SECURITY vs. INSECURITY

If a child feels secure in his relationships, which in the early years are mainly those with his parents, in the sense of feeling accepted, approved of and loved, then he will feel comfortable in expressing his feelings freely in the full expectation that they will be understood. However, early in his life he finds that certain of his feelings, whether they be fears or angers or loves or hates, run counter to the interests or desires of his parents, or in other ways prove unacceptable to them. Since he is in no position to end his dependency upon them, it becomes important that he apply the brakes upon such self-expression, or that he express himself in ways which release the tension in his feelings without taking the risk of displaying the true feelings themselves. Thus parental disapproval or lack of parental acceptance or threat of loss of parental love can lead to a sense of insecurity in his relationship to his parents—a sense of insecurity which manifests itself by a fear of and withholding of his feelings, or by distortion of them through various types of symptomatic behavior which in indirect ways may serve to handle his anxiety about the relationship. Perhaps the parental disapproval isn't actually present at all, but if the child thinks it is, it amounts to the same thing and he reacts to it in the same way.

Since growing up is a continual process, and the child's feelings about himself and others in his environment go on constantly, even when he is asleep, there are an infinite number of places where things can go wrong. Happily, these are usually merely ripples in the main stream of his growth process, but at times they take on more significant proportions. We may consider these situations as points where the child's emotional growth is blocked or meets a barrier. No attempt will be made here to discuss children whose emotional difficulties have taken on the aspects of major psychiatric disorders, such as the psychoses, but mention will be made of several of those behavior disturbances which by themselves, or in conjunction with one or more other disturbances, indicate the presence of such a block or barrier in the child's emotional growth and telegraph the possible development of more serious trouble if they are allowed to continue indefinitely without attention for the core of the relationship difficulty.

The child's feelings have their first impact upon his environment through his demands for food in early infancy. If this demand is met by refusal on the mother's part, or by lack of warmth and free-giving, and if the child's need for physical satisfaction, which is roughly equivalent at that stage to emotional security, has not been met, he may tend to try to console himself in ways which might lead at least partly to that satisfaction—by such things as thumb-sucking and blanket-chewing. In his later childhood when he meets other situations in which he feels lack of security—whether that feeling is justified in reality or not—he may fall back on his infantile method of seeking satisfaction within himself instead of trying to find it in a relationship. By this time, however, such an originally simple action as thumb-sucking may have taken on highly complex meanings as other feelings about himself in relation to others can be expressed at the same time. No longer is it simply a measure of self-consolation. He may have found that sucking his thumb irritates his parents and he can use it as a retaliatory gesture to get back at them for not meeting his current, and indirectly, his original, needs, at the same time flaunting in their faces the fact of how little real control they have over him. Or, wanting something from his parents that he cannot find in other ways, he may decide that it is valuable to him in establishing contact with them, even though the attention he gets takes the form of irritation or disapproval. It can also hold the element of withdrawal, as though he is telling his parents that he is self-sufficient and doesn't want anything from them anyway. It can mean any of these things or all of them, and when such oral activity is carried on to excess in later childhood, say from the fourth to the tenth or twelfth years, it strongly suggests that the child is off the beaten track to normal emotionality and indicates that the basic problem had its roots early in the child's infancy—that fundamentally he is a child whose early needs to be dependent and cared for have never been adequately satisfied.

Since really significant symptoms seldom occur alone, he frequently develops others, too, which point to the same relationship troubles—such

things as excessive crying, clinging, or obsessive fears which require that he be cared for constantly. Significantly, it is usually his mother who is the object of his frantic search for security.

SPECIFIC PROBLEMS

Many truly difficult emotional problems have their beginnings in the toilet-training period. Parents often term it "breaking", as though its primary purpose is to break the child's will. It isn't odd, then, that the child may frequently react to it just that way. If, by this time in his life, he has found that his safety and security lie in being conforming, the child will probably do his utmost to give when, where and how he is required. If his own need to become an individual, with the right to make some of his own decisions, is strong enough, however, he may fight what he regards as a coercive force by any means he can muster. He may hold back for all he is worth and lay the foundation for later reactions of similar nature, wherein as an adult he responds to authoritative situations by developing such symptoms as constipation. Or he may give, but on his own terms—when, where and how he desires, with the retaliatory element clearly in the picture. Such is the child who refuses to use the "potty" but a few seconds later soils his panties, perhaps hides them in strategic spots around the house, or sometimes smears their contents up and down the walls for good measure. Or, unwilling to conform completely, and yet not able to be so overtly stubborn and resentful, he may seem to be trying to conform outwardly but perform his excretory functions at times and places and in such manner that he can hardly be held responsible. The child who, for no organic reasons, continues to wet the bed has a nearly perfect way to avoid meeting his parents' requirements, a nearly perfect way of evading responsibility for his acts—after all, he does it in his sleep! Once these patterns develop, simple removal of parental pressure may not be enough to clear up the situation, since his reaction is by that time not a single conflict but representative of multiple relationship difficulties.

Eating problems, too, have their inception in difficulties encountered along the way as the child and his parents try to find what they can be in relation to each other. The parents, knowing that their child needs certain amounts and kinds of food and knowing that he has not the knowledge and experience to determine which he should have, may bend their efforts toward seeing that he conform exactly to their concept of correct nutrition. The infant who is forced to take an ounce more than he wants, however, may promptly regurgitate it. The older child whose mouth is figuratively, and sometimes literally, pried open so a spoonful of something he doesn't want can be jammed into it, may just as promptly spit it back, sometimes with deadly aim, or if he has to swallow it, he may vomit it at the first opportunity. Eating becomes one long struggle, and one which the parents cannot hope to win. They can cram and jam all they care to, but they cannot control the child's powers of anti-peristalsis. In this struggle for supremacy over whose right it is to determine what and how the child shall eat lie many of the more subtle and indirect eating and digestive difficulties of older childhood and adult life. When struggle, and its accompanying anxiety, creeps into other areas of the child's relationships, first with his parents and later with his playmates and teachers —or as an adult, perhaps, with his wife, his boss or his co-workers—he may find himself reacting with loss of appetite, indigestion, nausea, vomiting or other symptoms which show the extent to which his gastrointestinal tract is involved when he meets a situation he would like to refuse or cast out.

The dawning awareness of his body affords the child much pleasurable exploratory activity. Here his actions may touch upon many of the sexual anxieties which lie lurking in his parents' emotional patterns, and this activity may be met with demonstrations of parental concern, displeasure, or even punishment. Though his sureness of his acceptance in his parents' eyes may be sadly shaken, his curiosity about his body and its function persists and the feelings he has about it may be strong. He may, in order not to risk possible parental rejection, censor his impulses severely and, in repressing his earliest feelings about his sexuality, sow the seeds for later neurotic patterns. Or, if his impulse to explore is too strong to push down completely, he may take it to bed with him and indulge in genital play in the safety of privacy. He may, however, flaunt it openly before his parents, asserting his right to decide for himself what he does, and at the same time demonstrating a hostile and retaliatory attitude toward the coercive forces

which seem to be trying to thwart him. It is of great significance that, in his insecurity and feeling of being unloved and unaccepted, he may develop a pattern of depending upon himself for these satisfactions rather than finding them in a relationship. Masturbation or other genital play does not always signify this, but in the presence of a poor parent-child relationship it frequently does, and can lead eventually to the development of other, more serious symptoms which come about when a person tries to become sufficient entirely within himself for his emotional needs —such symptoms as abnormal daydreaming, pathological withdrawal, and the picture we know as the autistic child.

SUMMARY

The symptoms of emotional disturbance discussed so far are really disguised expressions of the child's feelings about what is happening in his relationship with his parents. Sometimes he is perfectly aware of the meaning of his symptoms, but usually he gradually forgets its original cause and has no understanding of its meaning if it occurs later when similar relationship difficulties arise. Sometimes, though, the child is unaware even of the original feelings and his symptomatic response to a sense of insecurity is less specific. For example, as the child grows he wants to begin taking increasing responsibility for what he does. Surely such assumption of responsibility needs parental guidance and support, but should he be constantly thwarted by an over-protective or over-insistent parent, or should no limiting structure whatsoever be provided for him, his anxiety may manifest itself in helter-skelter overactivity, the evidence of feelings which never get themselves expressd as such but come out as impulsive, thoughtless and purposeless actions. Failure by parents to recognize the meaning of this behavior frequently leads to lectures, threats or punishment, which further accentuate the child's feeling of insecurity and only heightens his need to conceal his real feelings of fear or anger or dismay. Temper tantrums, overt stubbornness, outright disobedience and other such direct demonstrations, though sometimes more troublesome than such symptoms as enuresis, are more nearly healthy, are more amenable to treatment and have a brighter outlook. These are present to some extent in every child's growing up, are usually grown through, and would hardly be worth mentioning if it weren't for the fact that sometimes the child's attempts to assert himself as an individual go beyond the bounds of socially acceptable behavior or are in the realm of the actually dangerous. We see disobedience becoming flagrant and all-embracing rebellion and refusal to acknowledge authority in any area. We see the impulse to strike out at annoying external forces becoming the hostile and apparently purposeless act of destructiveness or cruelty. We see temper tantrums becoming episodes of uncontrolled activity in which the individual seems hardly accountable. Or we may see crafty patterns of deceit. such as lying and stealing.

All such behavior, and many more specific examples which could be listed, bespeak the child's efforts to find satisfaction as an individual in relation to other individuals and represent the degree to which he has failed and to which others have failed him. He may, however, not get so far as to make this attempt in terms of behavior, and his struggle may be manifested not by habit and conduct disturbances so much as by neurotic traits in an otherwise acceptable child. His need to express his feelings, and his concomitant fear of doing so, may reveal themselves through stammering or sleepwalking or various tics and habit spasms. Or he may develop body symptoms such as headache or stomach-ache which serve the purpose of keeping from him the necessity of revealing his feeling more openly. All of these things are danger signs, indicative of something gone wrong in the fulfillment of his drive to achieve some sort of satisfactory place for himself among others—a place wherein he can feel himself as a complete person, yet part of a group of persons—someone with a sense of self plus a sense of belonging, neither of which can, by itself, be sufficient for his happiness, contentment and security.

Treatment of Insomnia with Special Reference to Valmid

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INSOMNIA IS INABILITY TO SLEEP or abnormal wakefulness. It may be a primary or a secondary complaint. As a secondary symptom it is usually intermittent. This restless or broken sleep is most commonly associated with disturbing dreams. These dreams may arise from "mental fatigue," but usually arise from indiscretions in eating and/or drinking during the evening hours. Other common and more easily recognizable symptoms producing insomnia are itching, coughing, and pain. Unless the causes of secondary insomnia are recognized and successfully treated, a short-acting sedative will not be found a satisfactory drug for these patients. A moderately long-acting drug such as Amytal Sodium is required by them. No drug can be given in doses which will maintain sound sleep throughout the night and then allow refreshed awakening in the morning. Drugs do not suddenly disappear from the body after a specified period of time. One of the best examples of this problem is found in hospitalized patients. On a noisy ward, a short-acting sedative will help the patients go to sleep but they may be awakened a few hours later by the activity around them. Drugs with a longer duration of action may be effective throughout the night. If the patients have a "hangover" in the morning they aren't going anywhere anyway.

Primary or simple insomnia may be classified as (1) initial, and (2) early morning. Initial insomnia is the delayed onset of sleep. It is the common variety resulting from anxiety and worry. When a patient has insomnia in acute form a comfortable resting place, quiet surroundings, reassurance to relieve anxiety, and small or sedative doses of drugs "to quiet the nerves" will induce sleep. A short-acting drug is ideal for this purpose. It assures fresh awakening in the morning and less confusion and stupor in the middle of the night should a personal or a household emergency arise.

When initial insomnia becomes chronic it may be a major medical problem. Sleeplessness accentuates the nervousness of the patient. It creates a fear of sleeplessness which is added to all of the other worries. Thus a disadvantageous cycle is established. More intense or psychiatric assistance and larger or hypnotic doses of drugs are required to assure the relief of tension and the onset of restful sleep. To avoid "hangover" and "middle of the night stupor" from these larger or hypnotic doses of drugs, it is very essential that the drug be inactivated promptly. Larger doses of longer acting sedatives such as Glutethimide or Amytal Sodium will produce severe hangover. The former drug also causes serious skin rashes and other undesirable effects. of elderly people. With advancing age, people

Early morning insomnia is often a complaint are thought to require less and less sleep. In truth, they fatigue early and are apt, therefore, to take an afternoon nap and/or to go to bed shortly after supper. As a result they are "slept out" early in the morning, awaken, and "putter about the house". In these patients a change in sleeping habits occurs which accentuates this early to bed, early to rise routine. If they were enabled to get back to sleep when they awaken to urinate in the early morning, they would be less fatigued the following evening and would be more apt to enjoy the sociability of that time of day. There is hesitancy in prescribing or

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taking any sedative within a few hours of arising. Even the shortest acting of the barbiturates, Seconal Sodium, may produce a "hangover" if taken in the middle of the night. A very short-acting hypnotic is essential to the treatment of this early morning rising if the patient is to be alert the following day. Valmid, a new, non-barbituric acid sedative, is sufficiently short in action so that it can be given up to four hours before the desired awakening time. It may be used whether or not it or some other sedative was taken at bedtime.

One other problem in the use of sedative drugs is the occurrence of excitement rather than sedation in some patients. This is observed most frequently in the very young and the very old, but occurs in any age group. There are no reports that Valmid produces excitement in these patients. It may be ideal for their treatment as well as the treatment of patients allergic to the barbiturates.

Valmid is a new sedative, chemically unrelated to the barbiturates. When given orally or intravenously to animals or man, it produces central nervous system depression without producing convulsions or significant changes in respiration, pulse, or blood pressure. Gradually increasing doses will result in sedation, hypnosis, narcosis or anesthesia, and death by respiratory failure. Studies for acute toxicity indicate a margin of safety equal to chloral hydrate and the barbiturates. Chronic administration has not produced evidence of tolerance, physical dependence or damage to kidney, liver, or bone marrow. No specific contraindications to its use have been discovered.

Valmid* has been marketed in Europe as Valamine for the past two years. It is a stable, non-irritant, colorless, odorless, bitter, crystalline solid. Since it is a non-irritant, stable solid, tablets for oral use can be prepared readily. The bitter taste has prevented the preparation of palatable liquids. It is insoluble in water; therefore satisfactory parenteral preparations have not been developed. Rectal administration has been unsatisfactory.

The original testing of the sedative effects was done in West Germany. Franke (1954) found that when Valmid was taken orally it usually produced dreamless sleep, starting within one-half hour and lasting about seven hours. He emphasized the excellent tolerance to the preparation and the completely fresh awakening in the morning. He states that Valmid is, therefore, particularly suitable for working persons.

A comparative study done on humans (Gruber, 1955) demonstrated 1.5 grams of Valmid to be as potent as 300 mg. of Seconal Sodium. This suggests that 0.5 gram of Valmid is about equivalent to 100 mg. of Seconal. The onset of the effects was approximately the same with the two drugs. The duration of the depression produced by Valmid was about one-half as long as that produced by Seconal. This very short duration of sedative action results in fresh awakening and therefore it is possible to administer a dose in the early morning should the need arise. The short duration and sedative action also make Valmid an unsatisfactory anticonvulsant. A good anticonvulsant should have little sedative effect and a long duration of action.

Similar studies (Gruber, 1955) using hypnotic doses indicate that 1 gram of Valmid is as potent as 1.5 grams of chloral hydrate. It does not produce gastric irritation as is often seen with chloral hydrate. A double-blind comparison made by E. L. Foltz (1955) confirms this potency ratio between these two drugs. He used both drugs as night-time sedatives for the same patients. Most of his patients stated that they preferred Valmid to chloral hydrate.

When a new central nervous system depressant is marketed, attempts at suicide usually are made with it. In Germany, 39 patients have attempted suicide with Valmid. One American soldier took 16 grams as a single dose. He was in a comatose condition for several hours. Six hours after this suicide attempt, he was relatively asymptomatic (Wright, 1954). Other patients have taken doses of 28 grams and recovered. Only two of the 39 patients died, one due mainly to an extreme and long lasting super-cooling and the other when a handful of other central nervous system depressants were also taken (Krull, 1955). The treatment in attempted suicide should consist in the removal of unabsorbed drug, supportive oxygen therapy, and artificial respiration. The administration of an analeptic is left to the discretion of the physician. Dr. K. K. Chen (1955) found picrotoxin to be the best analeptic in animals.

The treatment of patients who have taken large amounts of Valmid is essentially the same

* Valmid (Ethinamate, Lilly).

as when overdoses of barbiturates are taken. The recovery from large doses of this new drug is, however, much more rapid. Similar findings have been observed in animals. The ratio of the lethal (LD_{50}) to the hypnotic (HD_{50}) dose is as great with Valmid as with any of the central nervous system depressants. This large safety factor makes any special caution label unnecessary on the bottle.

Accurate quantitative studies on blood, tissues, and excreta have not been possible. There are no sensitive tests for Valmid. Some clinical and pharmacologic information is available which suggests that many or all tissues of the body inactivate this drug. In the presence of abnormal liver function, the duration of sedation is not increased (Maring and Suchowski, 1954). This is evidence that the liver is not the principal site for its deactivation. A patient with terminal renal damage received 1 gram doses four times a day and showed no accumulation or prolonged effects. Also, Dr. Chen (1955) found that when the best chemical tests available were used, it was impossible to show a significant quantity of Valmid in the urine after large doses were given. Therefore, the kidney does not appear to be the site of inactivation. Deactivation of Valmid in many parts of the body would account for its short duration of action. It may also be the reason that no diseases have been discovered which contraindicate its use whenever a sedative is desired.

The use of a sedative drug may become a habit just as the use of a crutch may be habitual. True addiction depends upon the development of tolerance and physical dependence. Addiction is present if characteristic withdrawal symptoms occur when the drug is stopped. No withdrawal symptoms have been observed in any of the patients treated with Valmid. In fact, it would be extremely difficult to produce addiction to a drug with such a short duration of action.

What then should be expected of a short-acting sedative such as Valmid? The anesthesiologists use sedative drugs for pre-anesthetic medication. They do this to reduce the patient's anxiety toward the operation (to produce euphoria), to remove the patient's memory of the anesthesia (to produce amnesia), and to decrease the quantity of general anesthetic necessary during the anesthetic period. Valmid apparently does not produce euphoria. It will cause amnesia and decrease the amount of general anesthetic required. However, since it has a short duration of action, the patient must arrive at the operating room on time. This is often impossible and through delay the pre-anesthetic effects of Valmid are lost. Therefore, anesthesiologists may find longer acting drugs superior to Valmid.

Psychiatrists deal with severe anxiety, severe insomnia, and functional brain disorders. Most of their patients have received large doses of barbiturates for a long period of time. These patients like the euphoria frequently produced by the barbiturates, and need continuous sedation. Valmid has not been found a good substitute because of the lack of euphoria and the short duration of effectiveness.

SUMMARY

Valmid is for the treatment of insomnia. Five-tenths to 1 gram doses are usually effective. A few individuals may require hypnotic doses of 1.0 to 2.0 grams. It has all the advantages and all of the limitations of a truly short-acting, orally administered sedative. It must not be expected to produce prolonged rest in patients under severe stress or exposed to frequent disturbances. It will produce restful sleep in persons with mild or moderate anxiety. Individuals who awaken early in the morning may take the full sedative dose four hours before the expected time of awakening. It is, therefore, especially of value in elderly patients or working persons who tend to awaken early and cannot get back to sleep.

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Cardiac Arrhythmia Due to Use of Chloral Hydrate

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CHLORAL HYDRATE was synthesized in 1832 by Liebig and introduced into medicine by Liebrich in 1869. Despite the fact that it is the oldest member of the hynotic group, surprisingly little has been reported of its toxic effects in man. Death is reported to result from respiratory depression. According to Goodman and Gilman "untoward cardiac effects occur only with toxic doses in patients with heart disease." Drill states that "although it is not recommended that chloral hydrate be used in patients with severe cardiac disease because an error resulting in overdosage might have adverse effects upon the heart, such an action has never been reported in persons with normal myocardium." In large doses, chloral hydrate has a direct depressant action on heart muscle—causing a reduction in contractility and a shortening of the refractory period of myocardium.

The paucity of information regarding the toxic effects of chloral hydrate on the human heart prompted us to report the following case, which to our knowledge is the first reported case of the adverse effect of the drug on the myocardium.

CASE REPORT

The patient, a 40 year old white female, was admitted to the Indianapolis General Hospital on 4-2-55, about 45 minutes after having ingested 12 gm of chloral hydrate.

Past history (obtained after the patient recovered) revealed brain surgery at the age of 10 for the removal of a "tumor". She has been in excellent health since.

Social history disclosed that the patient's husband was under psychiatric care and was given chloral hydrate as a sedative.

Physical examination on admission revealed the patient to be comatose failing to respond to any stimuli. The neck veins were slightly distended. The blood pressure was 60 mm. Hg systolic and 40 mm. Hg diastolic. The heart was not enlarged. Auscultation disclosed a grossly irregular apical rate of over 200 beats per minute. The radial rate was about 200 beats per minute. The respiratory rate was 36 per minute. The remainder of the examination was negative.

Laboratory studies disclosed a normal hemogram, urinalysis, serology, CO_2 combining power, blood urea nitrogen and blood sugar. Electrocardiogram taken on admission (figure 1) showed auricular fibrillation with ventricular rate of about 180. Many of the beats exhibited aberrant conduction and occasional ventricular premature systoles were noted. An EKG taken six hours later (figure 2) showed a sinus tachycardia and slight depression of S T segments in V5. An electrocardiogram at time of discharge was normal. (figure 3)

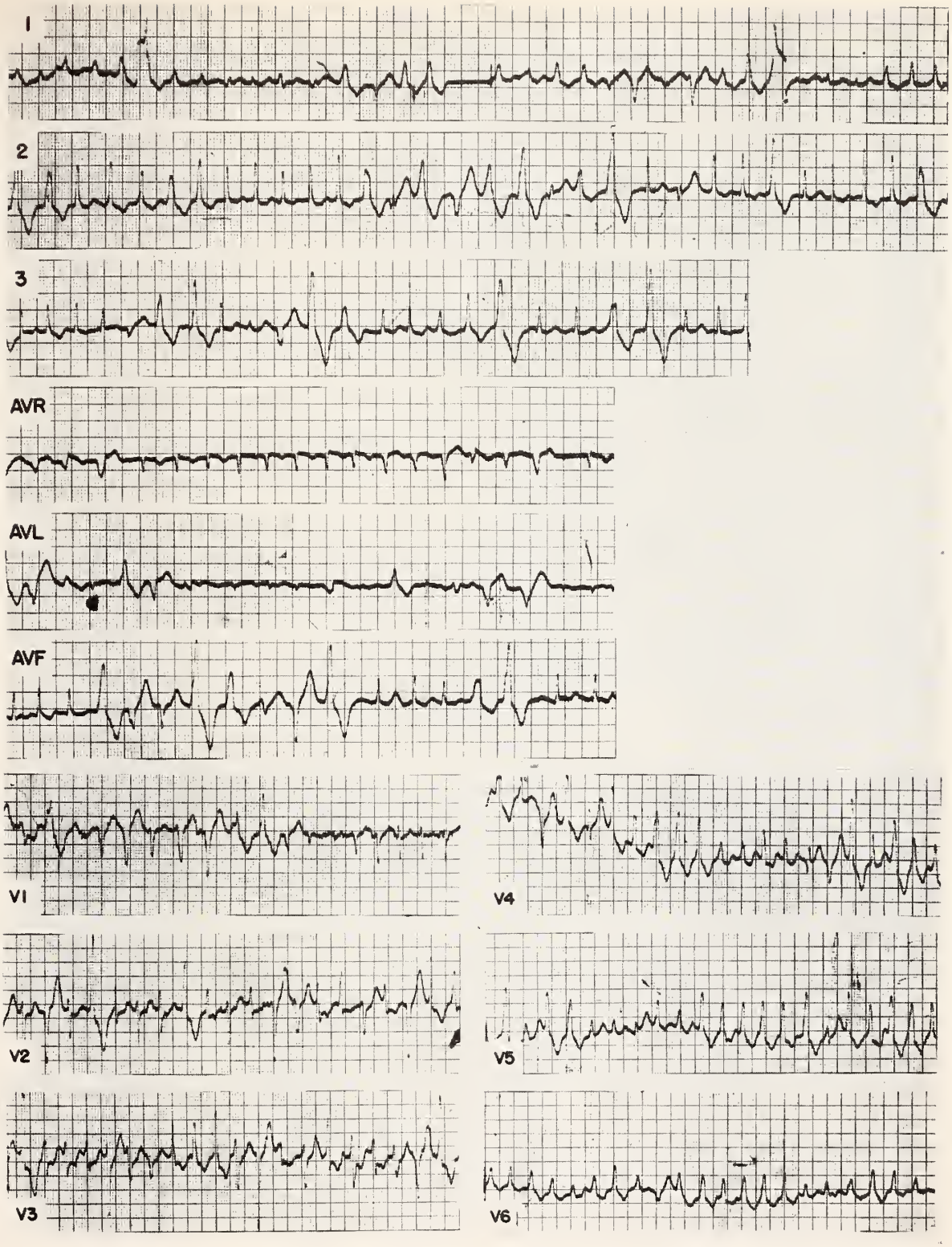
Following admission to the hospital the patient was treated with caffeine sodium benzoate, gastric lavage and intravenous fluids. The patient recovered gradually so that at the end of 24 hours she was normal except for a severe headache which subsided on the next day. Cardiac evaluation after recovery failed to disclose any evidence of heart disease.

COMMENT

Death from chloral hydrate overdose is reported to result from its severe central nervous system depressant effects. However, in this case the cardiotoxic effect of chloral hydrate was par-

From the Robert M. Moore Heart Clinic, Indianapolis General Hospital, Indianapolis 7, Indiana.

Figure 1.



ticularly prominent and appeared to pose more of a threat to life than did the respiratory depression.

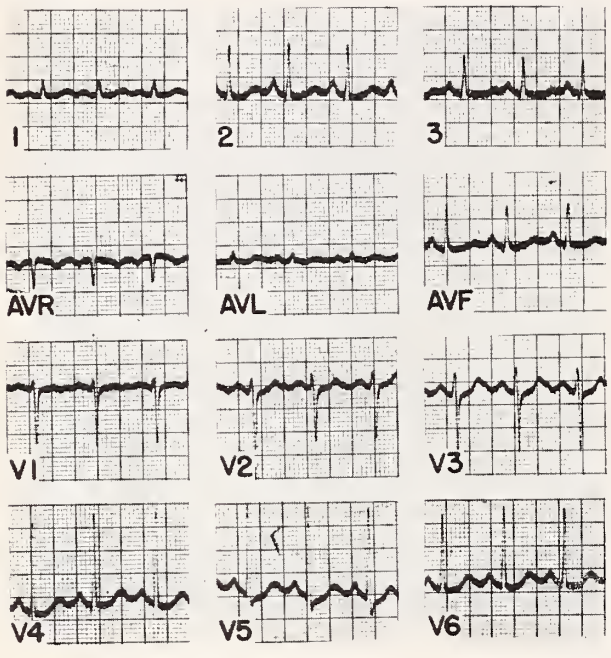
It seems reasonable to assume that the auricular fibrillation resulted from direct toxic effects of chloral hydrate on the heart. A study of the tracing leads us to the belief that the majority of the bizzare appearing ventricular complexes were due to aberrant conduction of supraventricular impulses. This was supported by a lack of fixed time relation of the bizzare complexes to preceding normal complexes and the lack of compensatory pause following the bizarre complexes. There were a few complexes which were

followed by a definite compensatory pause and probably represented premature systoles.

SUMMARY

An instance of the cardiotoxic effect of chloral hydrate on a normal heart is reported.

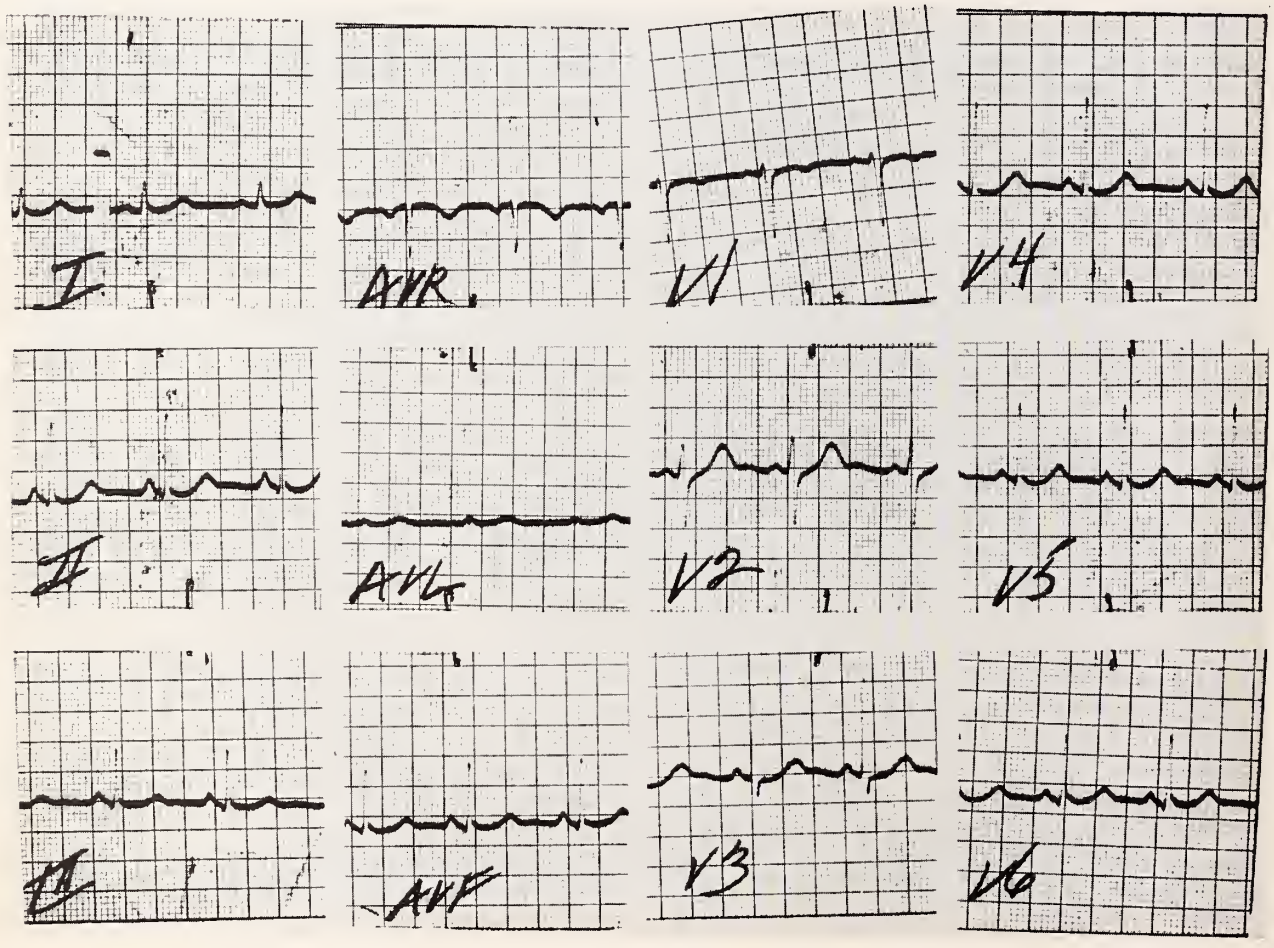
Figure 2.



NEXT MONTH'S ISSUE

Members of the Robert M. Moore Clinic staff at Indianapolis General Hospital have written all scientific papers which will be published in The JOURNAL in February. Following the custom of the last few years that number will be the Heart Issue. An unusually large scientific section has been prepared. Five papers have been contributed by members of the Clinic staff and five case reports written by residents in medicine at Indianapolis General Hospital. The subject range is wide.

Figure 3.



The Journal
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ECONOMIC POSITION OF MEDICAL CARE

THE QUARTER CENTURY from 1929 to 1954 witnessed a 30 percent increase in the population of the United States, from 122 million to 158 million.

During the same period the gross national product rose from 104 billion to 365 billion dollars and personal consumer expenditures were upped from 79 billion to 230 billion dollars.

This remarkable economic development took place at a time when medicine was also undergoing profound changes. The healing art has probably enjoyed more advancement in the past 25 years than in any 100 year period before.

Other developments have modified the economics of medicine. The nine years from 1945 to 1954 witnessed a phenomenal increase in the birth rate. Also, the latter part of the quarter century has been characterized by a rapid enlargement in that segment of the population over the age of 65. All these changes, both medical and economic, contribute a special interest to a review of the economics of medical care*.

Since 1929 the percentage of personal consumer expenditures going for medical care has varied from 3.99 to 4.35. This percentage figure has been remarkably constant through good times and bad, and the greatest rate of increase has occurred since 1946, in which time the figure has risen from 4.14 to 4.35.

The number of births has increased from 2,700,000 to 3,900,000 in this same period of time. While no statistics are available on this point, it is probable that the growth in obstetrical and pediatric care is largely responsible for the rising percentage of personal expenditures devoted to medical care.

Another item which tends to raise the medical care percentage is the overhead cost of medical and hospitalization insurance. Since 1929 there

* Bulletin 99, Bureau of Medical Economic Research, American Medical Association.

has been an increase of 779 million dollars in the administrative cost for medical insurance. This is the difference between premiums and paid claims. This is a necessary expense incident to obtaining the benefits of insurance, but it does raise the cost of medical care without representing a similar increase in the amount of medical care received.

In consideration of the two above named factors, it is almost certain that the higher percentage of expenditures now going for medical care does not indicate that the health of the country is worse. Nor that medical care is costing any more when measured by the general increase in the cost of living.

Another way of analyzing the cost of medical care is to determine what percentage of each dollar is received by physicians, dentists, hospitals, or is spent for drugs or other items. Since 1929 the physicians' share of the dollar has declined from 33 cents to 28 cents. The share for dentists has declined from 16 cents to 10 cents, drugs from 20 cents to 16 cents. The portion received by hospitals has increased from 14 cents to 26 cents. The "all other" classification which includes the overhead cost of insurance has risen from 17 cents to 20 cents.

Since the average physician's income has risen almost exactly at the same rate as the income of wage and salaried workers, the doctors' share of the medical dollar can be explained only by the fact that there has been a considerable increase in productivity on the part of physicians. "The effective supply of physician's services has increased much more rapidly than the number of physicians".

More patients are seen in offices today, more auxiliary personnel assist the doctor in his office and in the hospital, new drugs are more efficient. These factors tend to make the physician's efforts more effective and allow him to care for more patients each day, and to do so more efficiently.

SOCIAL SECURITY—BIG ISSUE IN '56

EVERY PHYSICIAN who is conscious of his duties as a citizen should now be taking an active interest in a timely issue which the American Medical Association considers of great importance—not only to the medical profession but to all of the American people.

That issue is HR 7225, a bill passed by the United States House of Representatives last summer near the end of the Congressional session. This bill, known as the Social Security Amendments of 1955, was first rushed through the House Ways and Means Committee *without public hearings*. Then it was passed in the House, by a vote of 372 to 31, *under a suspension of the rules which barred amendments and limited debate to 40 minutes*. The Senate Finance Committee, however, refused to take hasty action on a bill of such major importance. After hearing the many serious questions raised by Mrs. Hobby, then Secretary of the Department of Health, Education and Welfare, the Committee decided to hold extensive public hearings during the second session of the 84th Congress.

Just what is this legislation that appears to be so politically attractive to individuals with an eye on the 1956 elections? Why was the House majority leadership so determined to avoid open hearings and normal debate? Let's take a brief look at the main provisions of the bill.

This is the legislation which would lower the Social Security retirement age for women from 65 to 62; extend monthly benefits for permanently and totally disabled children beyond the age of 18; expand compulsory social security coverage to all self-employed professional groups except physicians, and raise social security taxes over and above the increases already scheduled for the next 20 years. Those provisions alone demand careful study of their effects on the philosophy, scope and financial stability of our social security system.

The most controversial section of the bill, however, is the one which would make permanently and totally disabled persons eligible to receive their social security retirement benefits at age 50 instead of 65. It is this section which

is of particular concern to the medical profession. It is of far greater concern than the question of voluntary or compulsory coverage of physicians under the social security system. That is a separate issue which we are not discussing in this editorial. The plan for a national system of permanent and total disability benefits has far more serious implications for medicine and the nation.

SOME QUESTIONS

It raises questions such as these: Is there any real need for a federal program? What are the facts on permanent and total disability? Won't this duplicate or overlap existing programs of assistance and rehabilitation? What effect will cash handouts have on a patient's incentive to be rehabilitated? Won't this extend federal control over physicians?—and, finally—How will this affect the future of medical practice? Will this lead, step by step, to the lowering and eventual elimination of the age-50 eligibility requirement; then, cash benefits for the dependents of those who are permanently and totally disabled; then, a temporary disability benefits program; then, cash benefits or direct government payments for hospital or medical costs, and then, ultimately, a full-fledged system of Government health insurance?

These are but a few of the many grave questions which already have been raised concerning this legislation. As physicians, we must be concerned over the medical aspects of the problem. As citizens, we also must be concerned over the trends and implications in the never-ending expansion of our social security system. The minority report of the House Ways and Means Committee expressed it this way:

"We do not believe that our committee has discharged its obligation to either the Congress or to the American people by its brief and closed-door consideration of this vital legislation. We have sought to point out the grave social and economic implications of the bill. We have dwelt at some length with the staggering ultimate costs of this developing program, because we do not believe that either the Congress or the public has any conception of its magnitude."

Our social security system now has reached the point where any further changes may have a profound influence on the nation's economic, social and political future. The time has come to face up to the question of just what social security should accomplish and just where it should stop. The Association strongly *urges* that the social security issue be taken out of the arena of vote-catching politics; that there be an objective, thorough study of social security in all its present and future aspects, and that the facts and realities emerging from such a study be used as the basis for a sound national decision on this vital issue. It especially protests precipitate action on the complex question of disability without thorough investigation of alternative mechanisms.

In our opinion, that is a reasonable, responsible policy that deserves the moral and intellectual support of every physician.

FUTURE NURSES CLUBS

WITH THE PUBLICATION of a new "Program Guide for Future Nurses Clubs", the Committee on Careers, National League for Nursing, announced national sponsorship of Future Nurses Clubs which are growing rapidly in high schools throughout the country.

The 80-page book is designed to help clubs become "a setting in which young people who are interested in nursing as a career can meet together to share that interest, to explore the opportunities and requirements in the field, to grow as individuals by working together and to learn about the community life in which they soon will participate as informed citizens and possibly as nurses".

The booklet suggests program techniques and resources to help club members acquire personal grooming and health habits and learn about the nursing and health services that work to improve living standards throughout the world.

The Program Guide describes many community health and welfare projects in which high school students may participate. It sets down guidelines for teen-age volunteer service

as hospital aides and discusses the ways in which clubs can develop other local and international service projects. The organization of city, county and state groups of Future Nurses Clubs is also outlined.

There are about 1,400 Future Nurses Clubs in the United States. The rise of these high school nursing clubs has been largely spontaneous. The National League for Nursing is now contributing national leadership and hopes to help the clubs multiply and to develop sound programs.

It is felt that the clubs and their informational programs may be as important in discouraging girls who would be unhappy in nursing, as they will be in recruiting suitable candidates for nursing careers.

Copies of the book "Program Guide for Future Nurses Clubs" may be obtained at a price of 50 cents from National League for Nursing, 2 Park Ave., New York, 16.

Guest Editorial:

THE BIG ISSUE

Coming is the biggest issue to face the medical profession since the defeat of Socialized Medicine . . . *SOCIAL SECURITY.*

Although the American Medical Association has done all in its power to defeat this issue, and has been successful to date, we find that very few doctors actually know what it is all about, how it will affect them, the good and bad features of it, and why the A.M.A. has opposed it.

Social Security first came into being in the United States in the depression year of 1935 and has been insidiously growing ever since. The last group left to conquer is the Medical Profession and the time is now ripe.

Come January 1st, the Senate will be asked to vote on a new facet for Old Age and Survivors' Insurance: "Permanent Disability Clause", which has already passed the House of Representatives.

This new clause will take permanent and total disability benefits out of PUBLIC ASSISTANCE, and place them under O.A. & S.I., where they no longer would require a *NEEDS TEST.*

The bad feature lies in the fact that the PHYSICIAN (YOU) will be called upon to determine and pass upon the existence or non-existence of a permanent and total disability. Again legislation compromises the medical profession in many ways, with the patient and physician forced into the enlargement of a Welfare State and an increase in taxes.

Here are some of its good features:

1. If a physician is employed, the premium is partly paid by his employer. He also is more apt to retire and at the age of sixty-five will be eligible for Social Security benefits, providing he does not earn more than $1200.00 per year.

2. Should he die young, then his wife would be eligible for benefits, the amount varying with the number of dependents. For example, a widow and one child could receive $162.80 per month; with more than one child, $200.00 per month until the children become eighteen years of age.

3. If the physician retired at age sixty-five, he could receive $98.50 per month. When his wife reached sixty-five the two would receive $147.80 per month. Note: Benefits are to be increased July 1, 1956.

Some of the reasons why the A.M.A. and physicians have opposed being included under OLD AGE and SURVIVORS' INSURANCE are:

1. Like Socialized Medicine, Old Age and Survivors' Insurance is compulsory legislation and smacks of adulterated Marxism.

2. The Physician, unlike the majority of the population, is self-employed and would pay into the system twice the amount the workers do.

3. Its financial soundness is questioned, since it has been estimated that this Old Age and Survivors' Trust Fund should have currently TWO HUNDRED and FIFTY BILLION DOLLARS in reserves instead of the TWENTY BILLION DOLLARS it does contain. It is placing unburdenable tax loads on our children and the citizens of the future.

4. Many today are receiving "Windfall Benefits", benefits which are out of proportion to the amount that they have paid in. Senior citizens of today are receiving bargains!

5. The manner in which the funds are received and used for current government expenses by converting them into future government due bonds is also questioned.

6. The future deficit the plan now has and will incur can only be balanced by unpalatable taxes in the future.

7. O.A. and S. Ins. is not insurance but a disguised program of old age assistance or mass charity without a *means test.* For example:

 a. There is a decreasing relationship between the amount of Social Security Taxes and benefits.

 b. There is no contract between the insuror and the insured. Congress can and does change the program at will.

 c. There is no loan or surrender value.

 d. When eligible persons aged sixty-five to seventy-two earn more than $1200.00, their benefits are reduced proportionately to nothing.

8. THE ONLY WAY TO POSTPONE THE DAY OF RECKONING FOR SOME TIME TO COME IS TO FORCE INTO THE SCHEME PERSONS WHO ARE NOT APT TO USE MANY BENEFITS. PHYSICIANS AND OTHER SELF-EMPLOYED PERSONS BEING THE PRIME CANDIDATES FOR INCLUSION IN THIS BAILING-OUT PROCESS.

Statistics show that thirteen thousand physicians in general practice are over sixty-five which is the conventional age for retirement.

Eight of every ten physicians over sixty-five are still in active practice.

One of every two in the group sees more than forty patients in an average week.

One of every four treats patients of all ages.

One of every four will handle all types of cases.

Three of every four do not accept surgical cases.

It seems clear, however, that the majority of the physicians over sixty-five remain important members in the health teams of their communities.

This is a very important issue. It requires your study and support. The bill has already passed the House of Representatives. In January it goes to the Senate and unless the American Medical Association has your support, through your intervention by voicing yourself to your Senator, it faces certain enactment.

It has been voted at the Executive Council that the District Societies poll their membership and record their vote with the State Society. This is necessary to actually find out how the medical profession stands on this issue.

It is requested that all who desire that this issue be defeated contact their Senator, by mail, telegram or, wherever possible, by personal contact NOW.

—Worcester (Mass.) Medical News.

The President's Page

IT WAS A CHARACTERISTIC of the Bourbons that they never forgot and never learned. Only fragmentary evidences of their once powerful status now remain.

It is within the range of possibility that the present security we enjoy may be lost. The profession rallied into a formidable show of strength five years ago, but have we not relapsed into much of that complacency which so nearly permitted our position to be overwhelmed and a proud profession reduced to a scramble for existence under rules and regulations in the making of which we did not participate?

Scientific progress has little to do with maintaining our position. It is an expected part of our social contribution, matching just as striking progress in other professions. Laymen accept as routine, our newer advances. Longer lives and better health are accepted without loud acclaim for us. Our strength lies in the opportunity to render personal service which directly affects the individual. To him, his own health, his own comfort, is of greater importance than impersonal advances. To him, the physician who helps his personal afflictions stands in the position once ascribed to mythical gods. And to such a person, most laymen defer and listen with complete belief. Any sick man regresses toward his childhood in seeking security from pain and death. As a child nothing was impossible from the parents. And in his adult age, the physician takes the place of father and mother. On this assumption, the physician secures his relation of implied faith and confidence and even affection. And this, my colleagues, is basic public relations.

Recently, I attended a large convention devoted to study of Public Relations. In the whole day, there was not a single mention of the basic element. Can it not be seen that extravagant advertising of our virtues makes little impression, that our joint efforts when publicized by costly fanfare receive only feeble applause, which is not converted into enthusiastic support. It is only those efforts which touch the individual which impresses. Solicitude and humanitarian conduct, fairness in compensation, readiness to serve, constitute the basic requirements for maintenance of our hold on the people. In too many places, prosperity has hurt us, the flamboyant exhibition of greatly increased incomes, limitation of hours of service, insistent demands of compensation in excess of the value of services or from the indigent, failure or unwillingness to accommodate ourselves to the needs of the people are undermining our claims of devotion to the welfare of the public.

If we lose our liberty of action and our cherished individuality, we, solely, will be to blame. Unfortunately, as a profession, we cannot control individuals but we at least can make united efforts directed toward alleviation of some of the complaints.

Any Society can set up a 24-hour call system and publicize it in newspapers and especially in phone directories. Any Society can establish a fair fee schedule based on average incomes, with provision for suitable and proper increases by pre-arrangement. Any Society can set up a central telephone to which physicians may report their whereabouts in event of absences from their usual places. Any Society can set up a Public Information Committee

to give the public, either as individuals or through newspapers or on the air, considered and approved statements of facts concerning medical matters of general interest. Any Society can offer to assist in any public movement concerning public health.

Such participations can result only in improving the confidence of the public in the profession as a whole.

The Medical Profession has been described as being divided as Gaul was, in three parts. One—the active member, always willing to help in every worthwhile action, willing to sacrifice some of his time for the profession of public good. Two—the complacent member, who is theoretically enlisted in the activities of the organized bodies, but actually does nothing more than occasionally attend a meeting. Third—a minority, who simply don't give a damn for anything that does not give them a personal profit.

The profession lives because of the first class. By some form of inciting interest, or even, by compulsory requirements of participation, many, if not most of the second class may be brought into class 1. The third class ought to be eliminated from our efforts and our councils. They are parasites and we will be stronger without them. Why should we hestitate to dismiss them by attendance rules, fair but sternly administered. Those who will not participate, ought not enjoy the benefits available to those who give freely of themselves, their time and their money. I am not a believer in the desirability of having every medical man in the Society. Let it be a privilege gained by effort and participation.

My Biblical knowledge is rather hazy, but I seem to remember that on several occasions, the Almighty did considerable culling out from the available forces. A strong, if small, Society is capable of influencing public opinion, because it does the things that the people expect of us. It leads in every worthwhile public health movement, it sells itself, as concerned with the welfare of all and accusations of self interest will not hold, and prosperity of the profession will not be begrudged.

Some of these participations will entail expense. We are too accustomed to participating in general prosperity, without paying our fair share of costs. Professional prosperity ought to be evidenced by liberal contributions to every worthy cause. There is a real satisfaction in sharing.

Traditionally, our profession has avoided and even scorned close participation in political life. Most have dodged personal and direct political responsibility, but we must live in such a world. Common sense demands that we recognize the desirabiity of "jining 'em if ye cain't beat 'em," and our best hope of continuing our status is by joining in every public movement concerning public health. We may not divert trends, but we can join in leadership and strongly identify ourselves with the public good.

And in all our efforts, let us not forget the charitable and humanitarian attitude traditionally belonging to our profession. There is great profit in attending the poor without charge. It improves our public relations, thus permitting adequate charges to those able to bear them, it pays direct dividends in later compensations, and it gives comforting and pleasing remembrances in your later years. Truly, it is returning bread, in amplifying quantities, that has been cast upon the waters of need and suffering.

W. H. Kennedy



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The Women's Auxiliary

REPORTS TO I.S.M.A.

With the coming of the new year we all have our resolutions for doing more with the opportunities that present themselves.

I wish to call your attention to the opportunity for establishing good public relations and bettering community health by educational information provided the people of your town or community through a Health Day Forum.

Dr. Joseph E. Dudding of Hope, Indiana is the chairman of the Committee on Rural Health of the I.S.M.A. His very able wife is promoting the publicity for the Auxiliary. I wish to turn the rest of my page over to Mrs. Dudding, since it is our sincere desire that all counties take advantage of the help offered and plan a Health Day program.

Sincerely,

Helen W. Mather

Mrs. J. Winford Mather, President

Bartholomew-Brown Medical Society Presents Health Day Forum

MRS. J. E. DUDDING

Hope

BARTHOLOMEW-BROWN COUNTY MEDICAL SOCIETY presented its Health Day Conference to a receptive public audience on November 16, 1955 at the Donner Center in Columbus, Indiana. The title of the conference was "For Your Health's Sake". Eighteen doctors and two laymen presented 10 minute talks on health and medical problems. Comments indicated that the audience wished more people could have heard it, and marveled that the physicians were willing to take time from their busy day to give them helpful information.

So it is evident what a powerful public relations vehicle these programs can be.

There were no embarrassing questions from the floor, only those desiring clarification of information. The most popular panel (over 50% of the return slips) dealt with tension and anxiety problems in everyday living. The highest number of requests were for more information about the adolescent.

Displays with pick-up literature were featured in one half of the room. The Auxiliary or County Health Council members manned these booths if the agencies did not send personnel. The Indiana Heart Foundation has a kit of information on preventing rheumatic fever which they will send to any group interested in planning a program. The Indiana State Police also have a safety kit available. All of the voluntary health agencies are more than happy to cooperate in these programs. There were also booths for Today's Health and Blue Cross-Blue Shield.

COOPERATION WAS GOOD

The publicity for such a meeting is the detail which will require the most time and energy. The newspapers and local radio station were most cooperative. The Agricultural Extension Office was very helpful. Cards were sent to all fraternal and social organizations requesting that they send representatives, and to all churches asking for an announcement in their bulletins. Health, nutrition and safety classes of the high schools were invited through the county superintendent's office. Every means available for publicity should be used.

It is good public relations to get as many physicians on the program as possible, however 10 minutes is almost too short a time to present even a part of a subject. Catchy titles will stimulate interest; long medical words are taboo. The Bartholomew-Brown panelists gave the audience a bit of good take-home information, and many misconceptions about medical care and health were corrected. A tape recording of three of the panels is available through the I.S.M.A. headquarters. The program as it was presented is on page ——.

Bartholomew-Brown County Medical Society and Auxiliary were glad to present the first in this series of health conferences, and hope that the other counties in Indiana will have the same enthusiastic reception.

SOME FACTS ON PHYSICIANS AND THEIR ESTATES

The Hartford County (Connecticut) Medical Society recently studied 144 obituaries of local physicians and probate court cases involving their estate. While the survey, of course, wasn't too large, it revealed some interesting and startling facts, including:

One out of eight of the physicians who died between 1940 and 1953 was in debt at the time of death.

Of the 144 doctors estates studied, one out of three left net assets of less than $10,000.

The Hartford survey disclosed only one extremely wealthy doctor out of the 144 and that $575,915 of his estate was consumed by estate taxes and other settlement expenses.

Only one doctor in eight survived his wife!

The doctors aged 40 to 50 died twice as fast as the general population, and in the 60-70 bracket, the doctors' death rate was 50 per cent higher than the insurance table.

Heart diseases and cerebral hemorrhage were the chief causes of death.

Expenses of settlement of the estates studied ranged from a minimum of 13 per cent to as much as one-third.

The age of death of the physicians when compared with life insurance mortality tables showed that there were two vulnerable age periods for medical men—40 to 50 and 60 to 70.

One out of three physicians left no will.

—A.M.A. Secretary's Letter

Summarized Report of Actions of A.M.A. House of Delegates in Boston

TWO RESOLUTIONS passed by the House of Delegates of the Indiana State Medical Association were presented on the floor of the House of Delegates of the American Medical Association at the interim session held in Boston November 29 through December 2.

Indiana's delegates, Drs. Cleon A. Nafe, Indianapolis; Alfred Ellison, South Bend; E. S. Jones, Hammond; and Wendell C. Stover, Boonville, served as spokesmen for the I.S.M.A.

Resolution No. 9 adopted by the I.S.M.A. House was passed after revision by the Reference Committee on Insurance and Medical Service; and Resolution No. 7 was combined with similar resolutions on the subject of Salk poliomyelitis vaccine before passage by the A.M.A. delegates. Resolution No. 9 sought the creation by A.M.A. of a continuing Committee on Medical Practice.

A roundup report of the proceedings of the Boston meeting follows:

Social security, the report of the Committee on Medical Practices, grievance committees and revisions of the code of medical ethics were among the major subjects of discussion and action by the House of Delegates at the American Medical Association's Ninth Clinical Meeting held Nov. 29—Dec. 2 in Boston.

Named as the 1955 General Practitioner of the Year was Dr. E. Roger Samuel of Mount Carmel, Pa., whose selection by a special committee of the Board of Trustees was announced at the opening session on Tuesday. Dr. Samuel, a former member of the House of Delegates and a general practitioner for 35 years, received the medal and citation presented annually for community service by a family doctor.

Total registration for the session was 8,637, including 3,779 physicians. More than 100 physicians gave scientific papers or participated in panel discussions.

Dr. Gunnar Gundersen, A.M.A. Board Chairman, who made the award to Dr. Samuel, also presented a special citation to Dr. Torald Sollmann of Cleveland, Ohio, charter member of the A.M.A. Council on Pharmacy and Chemistry for over 50 years and its chairman since 1936. Dr. Sollmann, 81 years old, was honored for his "outstanding service to the medical profession and on behalf of the advancement of medical science."

SOCIAL SECURITY

Major legislative policy action taken at the Boston meeting involved H.R. 7225, known as the Social Security Amendments of 1955. This bill, which was passed last summer by the U. S. House of Representatives and is now pending before the Senate Finance Committee, includes a proposal for federal cash benefits to selected individuals judged to be permanently and totally disabled. The House of Delegates adopted a substitute resolution proposed by the Reference Committee on Legislation and Public Relations to combine the intent of four resolutions and three supplementary reports of the Board of Trustees dealing with H.R. 7225 and other aspects of Social Security. The substitute resolution stated the following policy:

"That the American Medical Association reiterate in the strongest possible terms its determination to resist any encroachment upon the American system of medical practice which would be detrimental to our patients, the American people;

"That the American Medical Association urge and support the creation of a well-qualified commission, either governmental or private or both, to make a thorough, objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective non-political improvements to the Social Security Act, for the benefit of all of the American people;

"That the American Medical Association pledges its wholehearted cooperation in such a study of Social Security in the United States, and will devote its best efforts to procuring and

providing full information on the medical aspects of disability, rehabilitation and medical care of the disabled, and

"That copies of this resolution be transmitted to the President of the United States, to all members of the Cabinet, to all members of the Congress, and to all constituent state medical associations."

OASI COVERAGE OF PHYSICIANS

In another action on social security, the House passed the following resolution designed to determine the exact attitude of physicians toward compulsory or voluntary coverage under the social security system:

"Whereas, Misunderstanding exists about the position of the medical profession on the question of the inclusion of physicians in the Old Age and Survivors Insurance provisions of the Social Security Act; therefore be it

"Resolved, That the House of Delegates of the American Medical Association recommend to state societies that they poll their entire membership on this question and that the results of the poll be transmitted to the Board of Trustees of the American Medical Association as soon as possible."

REPORT ON MEDICAL PRACTICES

The House passed a substitute resolution offered by the Reference Committee on Insurance and Medical Service to implement the findings and recommendations of the Committee on Medical Practices (Truman Committee), which studied the basic causes leading to certain unethical practices and unfavorable publicity. The resolution, adopted with the proviso that it is subject to review by legal counsel, includes the following points:

"That a Continuing Committee on Medical Practice be created in the American Medical Association to conduct a study of the relative value of diagnostic, medical and surgical services and to report its findings and recommendations to this House in the same manner as is now followed by other committees and councils of the Association;

"That this committee shall consist of five members of the House appointed by the Speaker, three of whom shall be general practitioners; . . .

"That this committee be directed to utilize all possible means to stimulate the formation of a department of general practice in each medical school;

"That the American Medical Association approve of the medical school teaching programs which afford the medical student opportunity for experience in the general practice of medicine;

"That the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the County Medical Society concerned;

"That this committee cooperate in every way and assist the Public Relations Department of the American Medical Association to present a program of public education designed to bring about a better understanding of all fields of medical practice, and

"That this committee use its influence to discourage any arbitrary restrictions by hospitals against general practitioners as group or as individuals."

In a complementary action on the same subject, the House also approved a supplementary report of the Board of Trustees which included the following suggestions:

1. All non-surgical groups should be asked for their suggestions and cooperation in carrying out a public education program on the value of diagnostic and medical work.
2. The various specialty boards should be encouraged to reappraise the practice restrictions on their board diplomates.
3. The American Medical Association should continue to discourage arbitrary restrictions by hospitals against general practitioners.
4. Organized medicine is "ready, willing and able to solve satisfactorily its own problems, and such assurance should be given to the American Hospital Association or any other group concerning itself with such problems."

GUIDES FOR GRIEVANCE COMMITTEES

The House approved the report of the Committee to Recommend Guides for Grievance or Mediation Committees and commended the committee for "their superb approach to this prob-

lem." Purpose of the guides is "to promote general uniformity of organization and function of grievance committees—and better understanding of their purposes—without interfering with the inherent autonomy of constituent medical associations. Constituent associations are therefore urged to implement these guides without delay."

The Reference Committee on Miscellaneous Business made the following recommendations which were adopted by the House:

"Your reference committee desires to support the recommendation that a brochure be published promptly which will outline the recommendations regarding the activities of Grievance Committees and that this brochure be given wide distribution.

"We recommend also that there be an appendix to this brochure in which additional, practical suggestions shall be included.

"We desire also to support the contention that there should be no equivocation concerning the naming of such committees and we recommend that a uniform policy be adopted in which they are called frankly 'Grievance Committees.'

Finally, your reference committee recommends that because of the many variables, including the laws of the several states, which may influence the operations or procedures followed by State Grievance Committees, legal counsel shall be sought at the local level within the states."

MEDICAL ETHICS

A proposed revision of the "Principles of Medical Ethics and Precepts of Manners of the American Medical Association" was submitted to the House by the Council on Constitution and Bylaws. The following reference committee suggestion was adopted by the House:

"In discussion it became evident that there was need for wide distribution of these principles and careful study of the proposed changes not only by this Reference Committee but also by all members of the House and in fact all members of the Association. It seemed desirable also that the two Councils (Council on Constitution and Bylaws and the Judicial Council) should meet in joint session to consider these proposals. Your Reference Committee therefore recommends that these proposals be tabled for further consideration at the next annual session of the House to be held in Chicago in June, 1956.

"In the meantime, it is recommended that these proposals in their entirety be widely publicized and that consideration be given to publishing, in the Journal of the American Medical Association and also in state medical journals, these proposed changes in the Principles. It is also recommended that consideration be given to the mailing of copies to each member of the Association. Finally, your Reference Committee recommends that prior to the meeting in Chicago next June the Council on Constitution and Bylaws and the Judicial Council meet in joint session to consider these proposed changes."

In another action on revisions of medical ethics, the House also approved a plan requiring that all resolutions dealing with changes in the Principles of Medical Ethics shall be considered over a period between sessions of the House before final adoption.

MISCELLANEOUS ACTIONS

Among many other actions on a variety of other subjects, the House of Delegates also:

Recommended that the Board of Trustees give consideration to a dues increase for all Association members, with the increase designated for contribution to the American Medical Education Foundation;

Adopted a resolution on the practice of pathology declaring opposition to "the division of any branch of medical practice into so-called technical and professional services";

Recommended that further purchase and distribution of Salk polio vaccine be carried on by the presently available commercial avenues used for other immunizing agents, and that all vaccines, once proven, should enter the usual channels of distribution;

Approved appointment of an A.M.A. committee to study the prevention of highway accidents;

Commended the Women's Auxiliary of the A.M.A. for its financial contributions in support of medical education and requested the Auxiliary to continue its active efforts;

Commended the Sears Roebuck Foundation for its thoughtfulness and foresight in sponsoring the new plan for financial assistance in establishing medical practice units;

Received progress reports from the Commission on Medical Care Plans and from the A.M.A. Law Department on its studies of professional liability;

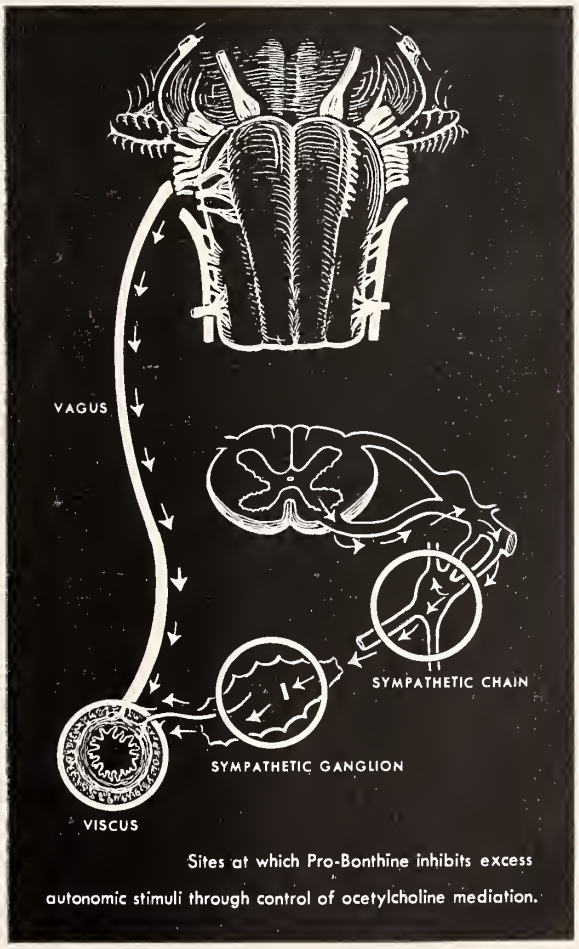
Approved a Board of Trustees recommendation that the State Journal Advertising Bureau

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Pro-Banthine (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is available in three dosage forms: sugar-coated tablets of 15 mg.; sugar-coated tablets of 15 mg. of Pro-Banthine with 15 mg. of phenobarbital, for use when anxiety and tension are complicating factors; ampuls of 30 mg., for more rapid effects and in instances when oral medication is impractical or impossible.

For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

Clinical trial packages of Pro-Banthine and the new booklet, "Case Histories of Antichalinergic Actian," are available an request to. . .

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be separated from the American Medical Association and be given full autonomy;

Congratulated the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right of the individual, and

Approved the selection of Minneapolis for the 1958 Clinical Meeting and Chicago for the 1960 Annual Meeting.

OPENING SESSION

Dr. Elmer Hess, A.M.A. President, told the opening session of the House that complacency should be regarded as the medical profession's greatest enemy. Although good progress is being made in informing the public and the profession of the objectives of organized medicine, he said, educational efforts must be intensified and the list of physicians' tangible accomplishments for the health benefit of the public must be increased.

Dr. Leo H. Bartemeier, Chairman of the A.M.A. Council on Mental Health, told the House that the new Joint Commission on Mental Illness and Health will be ready to embark on its nation-wide study and re-evalutions of the human and economic problems of mental illness after the first of the year. Dr. Bartemeier, who is Chairman of the Board of Trustees of the Commission, appeared before the House to explain the functions of the new commission, which was organized to carry out the Mental Health Study Act passed by Congress earlier this year without a dissenting vote in either house.

MEDICAL EDUCATION CONTRIBUTIONS

The A.M.A. Board of Trustees announced that it again has appropriated $100,000 to be contributed to the American Medical Education Foundation for the support of medical schools. The California Medical Association presented a $25,000 check to the AMEF, and the Utah State Medical Society announced an $11,000 contribution.

ENROLL NOW FOR POSTGRADUATE SEMINAR IN PSYCHIATRY

Have you sent for your registration material for the third annual Postgraduate Seminar in Psychiatry? Sponsors of the Seminar, the Committee on Medical Education and Hospitals of the Indiana State Medical Association, think this will be the most stimulating of the annual programs.

Dr. William H. Wood, formerly a faculty member of the Menninger Foundation School of Psychiatry and now clinical director of the Norways Foundation Hospital, Indianapolis, will organize and participate in several sessions of the seminar. "The emphasis in the seminar will be on psychiatric complications in general practice, geriatrics, environmental manipulation and therapeutic methods suitable to general practice", Dr. Wood said in urging physicians to send in their requests for registration material now.

The seminar is planned for March 28, April 4 and April 11 at the Child Guidance Clinic of Marion County in Indianapolis and sessions will be from 10:30 a.m. to 8 p.m. on each of the three days.

Advance fees will be refunded if requested within five days after receipt of the program in February.

Registrations should be sent to Psychiatric Seminar, Norways Foundation Hospital, 1800 East Tenth Street, Indianapolis 1, Indiana.

KNOX Protein Previews



New Booklet Presents Latest Facts on Feeding the Sick



Adequate nutrition during illness and convalescence is essential for recovery whether the patient is managed in the hospital or at home. In the latter case, physicians often must devote much time to instructing those responsible for caring for the sick in good nutritional practices.

"Meal Planning for the Sick and Convalescent" has been designed to relieve you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents in layman's language the latest nutritional applications of proteins, vitamins and minerals, gives practical hints on serving food to adults and children, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. Best of all it offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

If you would like copies of this new timesaving Knox booklet for your practice, use the coupon below.

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YOUR NAME AND ADDRESS

"For Your Health's Sake"

IN A STATEWIDE EFFORT to improve health in all communities, the Committee on Rural Health of Indiana State Medical Association, launched their 1955-56 project November 16 when the Bartholomew-Brown County Medical Society presented the first County Health Day Conference in Donner Center, Columbus. Scheduled for 9:30 to 3:30 o'clock the conference attracted more than 200 persons.

Other counties are planning similar programs. The Columbus program is published to show the wide participation by doctors in the program, and as a possible guide to other groups planning similar conferences.

9:45 a.m. WELCOME AND INTRODUCTORY REMARKS—J. E. Dudding, M.D., Hope, Ind.

10:00 a.m. HEALTH HAZARDS IN MODERN LIVING—Moderator—George Macy, M.D., Columbus
10:10 a.m. Highway Safety—Mr. Bert Reed, Indiana State Police
10:20 a.m. How to Avoid Injuries Upon Injuries—Lowell Beggs, M.D., Columbus
10:30 a.m. Eye Injuries—Alvin Henry, M.D., Columbus
10:40 a.m. Treatment and Mistreatment of Burns—W. J. Ryan, M.D., Columbus
10:50 a.m. Summary by Moderator and questions from the floor.

11:00 a.m. TENSIONS AND ANXIETY PROBLEMS IN EVERYDAY LIVING—Moderator, E. W. Williams, M.D., Columbus
11:10 a.m. Mental Health of the Child—Richard O'Bryan, M.D., Columbus
11:20 a.m. Anxiety in the Adolescent—Henry McCullough, M.D., Columbus
11:30 a.m. Tension in Geriatric Patients—H. J. Norton, M.D., Columbus
11:40 a.m. Psychosomatic Medicine—William Wissman, M.D., Columbus
11:50 a.m. Summary by the Moderator

Lunch will be available in the building from 12-1:30 p.m.
12:15 and 12:45—Movie "A Life to Save."
Time to examine the displays of your Health Agencies

1:30 p.m. WHAT'S COOKIN'—Moderator, Herman Echsner, M.D., Columbus
1:40 p.m. Help Yourself to Health—Miss F. Lusher, Dietitian, Bartholomew County Hospital
1:50 p.m. Good Eating Habits—Eleanor Clay, M.D., Columbus
2:00 p.m. Nutrition in the Young—Marvin Davis, M.D., Columbus
2:10 p.m. Nutrition in the Aged—Robert Krueger, M.D., Columbus
2:20 p.m. Summary by the Moderator and questions from the floor

2:30 p.m. AN OUNCE OF PREVENTION—Moderator, Griffith Marr, M.D., Columbus
2:40 p.m. Active Immunization—Donald C. Smith, M.D., Columbus
2:50 p.m. Salk Vaccine—Robert Reid, M.D., Columbus
3:00 p.m. Prevention of Heart Damage—W. S. Fisher, M.D., Columbus
3:10 p.m. Detection by X-ray—Howard Rothring, M.D., Columbus

HOOSIER "AT RANDOM"

During the Boston Clinical Session of A.M.A. a roving reporter asked five wives of physicians, "How can a doctor's wife be most helpful to her husband in his practice"?

Mrs. Harry Voyles, New Albany, answered: "The physician's wife should always try to fit her schedule to his. She should be sympathetic, courteous and efficient at the telephone. In addition to an interest in civic affairs, she should keep informed on medical matters because her answers to questions are sometimes over-valued."

Indiana Representatives at A.M.A. Boston Clinical Session Listed

OFFICIAL DELEGATES from Indiana to the American Medical Association Clinical Session in Boston November 29 through December 2 were Drs. Alfred Ellison, South Bend; Eli S. Jones, Hammond; Cleon A. Nafe, Indianapolis; and Wendell C. Stover, Boonville, all representing the Indiana State Medical Association; and Dr. Lester D. Bibler, Indianapolis, delegate for the A.M.A. Section on General Practice; and Dr. Lall G. Montgomery, Muncie, delegate for the A.M.A. Section on Pathology and Physiology.

Other physicians from Indiana who registered were: Catherine M. Balkema, Lafayette; Norman R. Booher, Indianapolis; Elton R. Clarke, Kokomo; F. S. Crockett, Lafayette; Lehman F. Dunning, Indianapolis; M. J. Galliher, Muncie; Frank Green, Rushville; D. M. Johnstone, Franklin; Philip Kurtz, Indianapolis; Wilbur J. Irish, East Chicago; W. P. Loh, Indianapolis; Josephine F. Murphy, South Bend; Anne S. Nichols, Greencastle; W. L. Portteus, Franklin; Daniel T. Ramker, Hammond; R. L. Sensenich, South Bend; Michael J. Sweeney, Evansville; Harry E. Voyles, New Albany; and Robert C. Ziss, Evansville, all listed as registering before November 30.

Others who registered were C. J. Maternowski, Valparaiso; G. B. Bowers, Kokomo; I. Mishkin, Elkhart; and G. M. Pfeiffer, Hammond.

Lay executives from Indiana attending the session were James A. Waggener, Franklin, executive secretary; and Robert J. Amick, Scottsburg, field secretary.

Indiana firms which exhibited were listed as the Ames Company, Elkhart; Central Pharmacal Company, Seymour; Depuy Manufacturing Company, Inc., Warsaw; Eli Lilly and Company, Indianapolis; Mead Johnson and Company, Evansville; and the Zimmer Manufacturing Company, Warsaw.

FEW PHYSICIANS OVER 65 RETIRE

A questionnaire sent to physicians over 65, the conventional age of retirement, reveals that: (1) eight of every ten are still in active practice; (2) one of every two sees more than 40 patients in an average week; (3) one of every four treats patients of all ages; one of every two sees chiefly patients between 40 and 60; and (4) one of every four will handle all types of cases; three of every four do not accept surgical cases.

Comments on some of the questionnaires showed remarkable activity on the part of some physicians well over 65. A Virginia physician, for example wrote: "I am now 86 years old and treat about 25 patients a week." Another wrote: "I can now state that I have a larger practice at 67 years of age than at any time in my 40 years of practice." Still another made the amazing statement: "On December 24, 1954, I was 90 years old. I have been in practice 60 years. I treat 40 or more patients a week, although I no longer do any surgery. Most of my patients are over 40."

Over-all results of the poll, published in the September issue of *Medicine in the News,* showed that while many physicians restrict their activities after 65, general retirement at that age for the majority seems not only undesirable but impossible.

—Orleans Parish Medical Society Bulletin Oct. '55

Deaths . . .

Henry W. Griest, M.D., retired Monticello medical missionary, died November 9 in his home after a three day illness. He was 87.

Dr. Greist, an ordained minister, spent 17 years as head of a Presbyterian hospital and mission at Point Barrow, Alaska. He and Mrs. Greist gave medical and spiritual aid to the Eskimos in a 1,000-mile area around Point Barrow.

It was Dr. Greist who gave the world details of the deaths of Will Rogers, famed humorist, and Wiley Post, who crashed in 1935 about 15 miles from the Greist mission-hospital. Dr. Greist prepared the broken bodies for shipment to the United States.

Born in Crawfordsville, Dr. Greist attended Hanover College and received his degree in medicine from the Medical College of Indiana in 1894. He first established his practice in Monticello in 1915 and five years later went to Alaska. He returned to Monticello in 1937, spent the next two years lecturing, and then reestablished his practice. He retired two years ago, after spending 52 years in active practice.

Dr. Greist was a senior member of White County Medical Society, a Fifty Year Club member of Indiana State Medical Association, and a member of American Medical Association.

Daniel B. Miller, M.D., Terre Haute physician for more than 50 years, died in his home October 19 following a two day illness. A graduate of Rush Medical College in 1903, Dr. Miller established his practice in Brazil where he remained for one year before going to Terre Haute.

He was a member of the Fifty Year Club of the Indiana State Medical Association, a senior member of Vigo County Medical Society, and a member of the American College of Surgeons and the American Railway Surgeons Association. Dr. Miller also held membership in church, lodge and civic organizations.

Martin L. Harshman, M.D., 42, Lafayette ophthalmologist and otolaryngologist, was found dead of a gunshot wound October 19. He had been in ill health.

A native of Mulberry, Dr. Harshman was a graduate of Indiana University School of Medicine in 1939. He was a member of Tippecanoe County Medical Society, the Indiana State and American Medical Associations.

Bension Scodel, M.D., 66, staff member at Muscatatuck State School, died in his Butlerville home October 21 from a coronary occlusion.

A native of Lithuania, Dr. Scodel came to America when a young man and received his medical degree from Tufts College Medical

School in 1921. He practiced in Minnesota for several years and during World War II came to Indiana where he was first affiliated with the Fort Wayne State School.

Donald W. Creel, M.D., 53, who had been in the practice of medicine in Angola for more than 20 years, died in Cameron Hospital, Angola, October 25. He had been in ill health for more than a year.

Dr. Creel, who was a 1933 graduate of the University of Chicago School of Medicine, was associated with the Cameron Hospital. He was a member of the Steuben County Medical Society, the Indiana State and American Medical Associations.

A. M. Kirkpatrick, M.D., retired Columbus physician, died October 31 at Lake Wales, Florida, where he had resided for the last 12 years.

A native of Rushville, Dr. Kirkpatrick was graduated from the Cincinnati College of Medicine, and practiced in both Rushville and Greensburg before establishing his practice in Columbus in 1890. He was a former member of the Bartholomew-Brown County Medical Society and the Indiana State Medical Association.

Walter C. Van Nuys, M.D., 78, who served as superintendent of the Indiana Village for Epileptics at New Castle from the time of its establishment in 1906 until 1952, died December 5 in the home of his son, Walter Van Nuys, Jr., in Dayton, Ohio. He had been in ill health for some time.

Dr. Van Nuys was born in Waveland and received his degree in medicine at Rush Medical College in 1902. He was a Fifty Year Club member of Indiana State Medical Association. He was also a senior member of the Indianapolis Medical Society. Since his retirement he had made his home at the Continental Hotel, Indianapolis. Dr. John D. Van Nuys, dean of Indiana University Medical School, is a son.

Joseph E. Moody, Jr., M.D., 41, medical director and superintendent of Boehne Tuberculosis Hospital, Evansville, died in the hospital December 7. He had tuberculosis and had undergone surgery several times to alleviate effects of the disease.

Dr. Moody, who succeeded Dr. Paul Crimm as Boehne superintendent, had been at the Evansville hospital since June 1, 1954.

The son of missionaries from the Christian church, Dr. Moody lived in India from the time he was two months old until he reached college age when he came to the United States and entered Transylvania College at Lexington, Kentucky, and later received his medical degree from the University of Louisville School of Medicine. He was licensed to practice in Kentucky, Ohio, Michigan and Indiana and had held several posts with sanitaria and hospitals.

Dr. Moody was a member of Vanderburgh County Medical Society, the Indiana State and American Medical Associations, the American Trudeau Society, and the American College of Chest Physicians.

Wilbur W. Ross, M.D., LaPorte physician and surgeon for 45 years, died suddenly in his

home there on December 8. He had been practicing and was not known to be in ill health.

Dr. Ross was a native of Illinois where he was born in 1879 and received his degree in medicine from Northwestern University Medical School in 1908. During World War I he served as a major in the Medical Corps. He was with a surgical unit in Europe for 18 months.

He was a member of LaPorte County Medical Society, the Indiana State and American Medical Associations.

Thomas J. Dugan, M.D., 78, physician and surgeon in Indianapolis for more than 50 years, died December 9 in St. Vincent's Hospital. He had been ill only a few days.

Dr. Dugan was born in Brownsburg but came to Indianapolis when young. He was graduated in 1901 from the Medical College of Indiana at Indianapolis and served his internship and residency at St. Vincent's Hospital where he delivered the first baby born in the present hospital. He had practiced in the same West Indianapolis neighborhood for 53 years where he had cared for several generations of many families. Dr. Dugan had served as physician and surgeon for the Baltimore and Ohio railroad for 30 years and for more than 20 years had been physician for the Indianapolis Home for the Aged.

Dr. Dugan was a member of Indianapolis Medical Society, the Indiana State and American Medical Associations.

Survivors include a son, Dr. R. J. Dugan, orthopedic surgeon at San Bernardino, California. Another son, Dr. Thomas J. Dugan, Jr., also a surgeon, preceded him in death.

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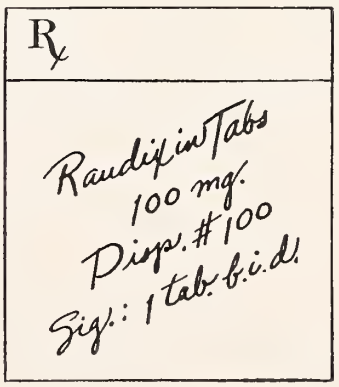
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*Ataractic, from ataraxia: calmness untroubled by mental or emotional excitation. (Use of term suggested by Dr. Howard Fabing at a recent meeting of the American Psychiatric Association.)



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NEWS NOTES — from State and Nation

ACS Sectional Meeting Scheduled for February 27-29

Handling of mass casualties will be one of the important subjects to be discussed by a panel of experts at the Sectional Meeting of the American College of Surgeons during the three-day meeting in Milwaukee, February 27 through 29, at the Hotel Schroeder. All members of the medical profession are invited to attend. Dr. Forrester W. Raine, Milwaukee, is Chairman of the Advisory Committee on Arrangements.

Among the topics to be considered are fractures in children, hypothermia in cardiac and general surgery, carcinoma of the prostate, tumors of the thyroid, cancer of the colon, intestinal obstruction, problems in operability, endometriosis, repair of nasal defects, and biliary tract surgery. Special hospital clinics will be offered on two mornings of this meeting. Medical motion pictures and cine clinic films will also be included in the program. The morning program for the first day will be a symposium on the handling of mass casualties.

Dr. V. K. Stoelting, Indiana University Medical Center, Indianapolis, was an instructor for the Sixth Annual Refresher Course program during the annual meeting of the American Society of Anesthesiologists, Inc., in Boston October 29-30. Dr. Stoelting's lecture was on "Anesthesia for the Urological Patient".

American Academy of Allergy Meeting to Be in St. Louis

The 1955 annual meeting of the American Academy of Allergy will be held in the Chase Hotel, St. Louis, on February 6, 7 and 8, 1956. There is no registration fee and guests are invited. Details of the program may be obtained from The American Academy of Allergy, 208 East Wisconsin Avenue, Milwaukee 2, Wisconsin.

Dr. C. O. McCormick, Indianapolis, was elected to the Council of the American Association of Obstetrics and Gynecology at its annual meeting held at The Homestead, Hot Springs, Virginia.

Indiana Man Named to AEC 12-Member Advisory Committee

Lewis L. Strauss, Chairman of the Atomic Energy Commission, has announced the establishment of a 12-member Advisory Committee of State Officials to consult with the Commission on regulations concerning health and safety aspects of private atomic energy activities. B. A. Poole, Director of the Bureau of Environmental Sanitation of the Indiana State Board of Health, was appointed as one of the 12 members.

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INTENSIVE POSTGRADUATE COURSES

STARTING DATES—WINTER-SPRING, 1956

SURGERY—Surgical Technic, Two Weeks, February 6, February 20
Surgical Anatomy & Clinical Surgery, Two Weeks, March 5
Surgery of Colon & Rectum, One Week, February 27, April 9
General Surgery, One Week, February 13, Two Weeks, April 23
Basic Principles in General Surgery, Two Weeks, April 9
Gallbladder Surgery, Ten Hours, April 9
Fractures & Traumatic Surgery, Two Weeks, March 12

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, February 13, March 12
Vaginal Approach to Pelvic Surgery, One Week, February 6, March 5

OBSTETRICS—General & Surgical Obstetrics, Two Weeks, February 27, March 26

MEDICINE—Internal Medicine, Two Weeks, May 7
Electrocardiography & Heart Disease, Two Week Basic Course, March 12
Gastroscopy, Forty-Hour Course, March 19
Dermatology, Two Weeks, May 7

RADIOLOGY—Diagnostic X-Ray, Two Weeks, February 6, April 30
Clinical Use of Radioactive Iodine, One Week, April 2
Clinical Uses of Radioisotopes, Two Weeks, May 7

PEDIATRICS—Intensive Review Course, Two Weeks, May 14
Neurological Diseases: Cerebral Palsy, Two Weeks, June 18

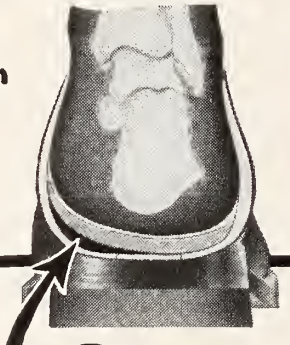
UROLOGY—Two-Week Course, April 16
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One Hill-Burton Grant Project Under Construction in Indiana

The October 31, 1955 report of the Department of Health, Education, and Welfare on the status of all Hill-Burton grants for Indiana discloses that one project is under construction with the federal government contributing $2,204,730 towards the overall cost of $7,273,474. The unit will provide 336 additional hospital beds.

No new projects have been approved for Indiana.

Since the passage of the Hill-Burton bill, Indiana has accepted 38 per cent of the total cost of construction of 42 projects from the federal government.

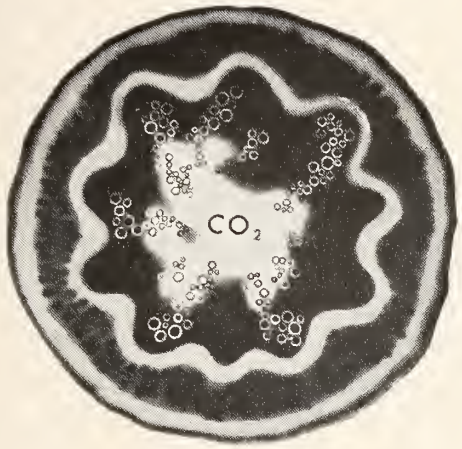
Dr. Lathan A. Crandall, Jr., director of the Miles-Ames Research Laboratory at Elkhart, was the speaker at an open meeting of the Elkhart County Association for Mental Health in the Nappanee American Legion home November 22. His topic was "New Drugs and Their Use in Mental Health". Dr. Crandall was formerly on the teaching staff at the University of Tennessee College of Medicine.

U. of Michigan Announces PG Courses for 1956

The Department of Postgraduate Medicine, University of Michigan Medical School, has listed brief review courses to be given at Ann Arbor during 1956.

The first course will be on Pediatrics-Obstetrics and Gynecology, January 23-28. Other courses offered are: Diseases of the Heart, March 12-16; Electrocardiographic Diagnosis, March 19-24; Metabolism and Endocrinology, March 26-30; Diseases of Blood and Blood-Forming Organs, April 2-6; Diagnostic Radiology, April 2-6; Diseases of the Gastrointestinal Tract, April 9-13; Recent Advances in Therapeutics, April 23-27; Opthalmology, April 23, 24, 25; Otolaryngology, April 19, 20 and 21; Radioactive Isotopes, as arranged; and Basic Sciences, October-June.

Information and application blanks will be sent by John M. Sheldon, M.D., Director, Department of Postgraduate Medicine, 1610 University Hospital, Ann Arbor, Michigan.



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The Congress of the Pan American Medical Women's Alliance will be held in Santiago and Vina del Mar, Chile, March 6-14, 1956. Trips have been planned before and after the Congress to include medical projects and programs in Mexico, Salvador, Panama, Chile, Bolivia and Peru. Information may be obtained from the Secretary, Dr. Eva F. Dodge, 2124 West 11th Street, Little Rock, Arkansas, or from the program chairman, Dr. Eva Cutright, Wooster, Ohio.

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Clinical Pathological Conference Held at Muscatatuck State School

The Muscatatuck State School, under the guidance of Dr. Hans Meyer, Clinical Director, has inaugurated a Clinical Pathological Conference. The first of the conferences was held at the school on November 25, with Dr. Orville T. Bailey, Professor of Neuropathology, Indiana University School of Medicine, as the moderator. Members of the Jennings and Jackson County Medical Societies, the staffs of the Louisville Child Guidance Center and the Madison State Hospital and the consultants for the school were guests. The conference is scheduled for a regular meeting twice each year.

A competitive examination for appointment of medical officers to the regular corps of the United States Public Health Service will be held in various places throughout the country on March 20, 21 and 22, 1956. Appointments provide opportunities for career service in clinical medicine, research, and public health. They will be made in the ranks of Assistant and Senior Assistant, equivalent to Navy ranks of Lieutenant (j.g.) and Lieutenant. Entrance examinations will include an oral interview, physical examination, and comprehensive objective examinations in the professional field.

Application forms may be obtained from the Chief, Division of Personnel, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D. C. Forms must be returned to Washington no later than February 10, 1956.

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Albert J. Crevello, M.D., Medical Director

Dr. K. R. Manning, Indianapolis orthopedic surgeon, has been elected to the national executive committee of the Conference of Rehabilitation Centers. He was named at the November national convention of the organization in St. Louis. Dr. Manning serves as medical director of Crossroads in Indianapolis.

Former classmates of **Dr. Morton D. Willcutts,** Vice Admiral, USN, (Ret.) recently received copies of the San Quentin News with a piece on the accreditation of Neumiller Hospital at the California State Prison at San Quentin. Dr. Willcutts has been chief medical officer at the prison since 1951 and is credited with making great forward strides in the medical facilities and being largely responsible for the conditions which resulted in full accreditation by the Joint Commission. Following his graduation from Indiana University School of Medicine in 1917 Dr. Willcutts entered the Navy where he had a distinguished career for 34 years. He was commanding officer at the U. S. Naval Hospital at Bethesda, Maryland, immediately prior to assuming his post at San Quentin where he supervises a staff of 20 doctors.

Evansville Doctors to Give Full Day's Program in Denver

Drs. W. D. Snively, Jr. and Michael J. Sweeney, Evansville, will present a program on "Fluid and Electrolyte Balance" on January 21 as the concluding feature of the six-day General Practice Review sponsored by the Clinical Departments and Office of Postgraduate Medicine, University of Colorado Medical Center in Denver. The presentation by the Indiana men will be in seven parts, commencing at 9 a.m. and concluding at 3 p.m. when they will participate in a panel with four Colorado faculty members and moderated by Dr. Joseph H. Holmes, professor of medicine and head of the Division of Laboratory Medicine and Clinical Pathology.

Drs. Snively and Sweeney are the only guest lecturers on the six-day program. Both men are in the Medical Department, Mead Johnson and Company. Information on the January 16-21 course may be obtained from the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, Colorado.

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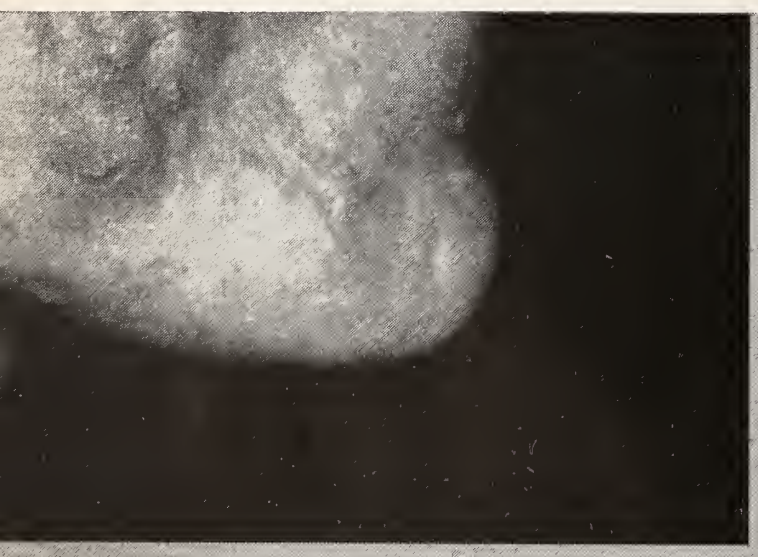
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of vitamin A

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is effective
in many
hyperkeratotic lesions

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	aqueous vitamin A**	ordinary oily vitamin A
acne	25,000 to 50,000 units daily	up to 500,000 units daily
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**Aquasol A Capsules (aqueous natural vitamin A) was one of the products used in these studies.

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three separate high potencies of natural vitamin A per capsule . . .
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25,000 U.S.P. units **50,000 U.S.P. units** **100,000 U.S.P. units**



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Hawaii Medical Association Announces Centennial Session

During the week of April 22-29, 1956, the Hawaii Medical Association will celebrate the passage of a century since its Charter of Incorporation was granted by the Monarchy of Hawaii.

Dr. Clarence E. Fronk, president, says in addition to scientific sessions with outstanding speakers from various parts of the United States, a great pageant depicting the colorful history of medicine in the islands, an Hawaiian feast, and planned sightseeing trips have been planned.

Ten physicians formed the Hawaii Medical Association in 1856. There are now 451 active members and 68 associate and honorary members with all recognized specialties represented and including 124 American Board diplomates.

Full information concerning the Centennial Celebration can be obtained from the Hawaii Medical Association, 510 South Beretania Street, Honolulu 13, T.H.

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OUR Policy embraces the belief that the Diagnosis and Treatment of Deafness lies within the special province of the Physician and, particularly, of the Otologist. We believe that our services complement those of the medical profession, therefore TELEX will always conduct its business so as to merit the Doctor's confidence.

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*Designed specifically for children**

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*Also well suited for adults who prefer a mild spray.

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Neo-Synephrine (brand of phenylephrine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U.S. Pat. Off.

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HOME LAWN Mineral Springs is maintained for those who need to tone-up for the strenuous duties of today's business and social world. All its facilities and all its employees are enrolled with the concern of aiding and administering in every way possible to make a sojourn at Home Lawn profitable from a health standpoint.

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HOME LAWN MINERAL SPRINGS
M. C. PITKIN, M.D., *Medical Director*
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THE MARTINSVILLE MINERAL SPRINGS
RAY D. MILLER, M.D., *Medical Director*

DONALD H. KENNEDY, *Executive Director*

Marion County Diabetes Statistics Compiled

During Diabetes Week private physicians in Marion County examined free of charge in their offices 2,229 persons and found 34 positive reactions for sugar.

A total of 2,243 persons returned Dreypaks to the Indianapolis Diabetes Association and of that number 225 were found to be positive or "suspicious".

The Diabetes Association, in cooperation with the Indianapolis Medical Society, maintained two telephones during the week, manned by volunteers. Calls were received from citizens from throughout the county in response to newspaper, radio and television publicity.

Thousands of additional tests were run in private industry as a continuing program as well as in the public school health program.

Dr. Alfred T. Symmes, Indianapolis, served as chairman of the special campaign to inform the public of the frequently unsuspected presence of diabetes and the need for early discovery.

Dr. Wm. Harry Howard, Hammond, past president of I.S.M.A.. is serving as Lake County chairman of the 1955 Christmas Seal sale for the Lake County Tuberculosis Association. In accepting the chairmanship Dr. Howard emphasized that tuberculosis is still a formidable threat to health, adding that 64 deaths occurred in Lake county last year and 225 new cases of the disease were discovered there.

The First International Congress of Human Genetics will be held in Copenhagen, Denmark, August 1-6, 1956. The congress is planned to cover all genetic aspects of normal and pathological characters in man. Any person interested in the subject of human genetics and especially of medical genetics is invited to take part in the congress. A provisional program and other information will be sent on request to The Secretariate of the First International Congress of Human Genetics, The University Institute for Human Genetics, 14, Tagensvej, Copenhagen, N., Denmark.

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Treating alcoholism and other problems of addiction.

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION— MEMBER AMERICAN HOSPITAL ASSOCIATION.

Evansville Doctors' Offices Ransacked for Narcotics

Most recent narcotics burglaries have been reported from Evansville where five doctors offices were entered and drugs, money, jewelry and other personal property stolen. A drug store was also burglarized during the same period.

Although entrances and desks were locked, a crowbar was used to enter a rear door and all desk drawers had been pried open.

Offices of Drs. Pierce MacKenzie, Edgar L. Engel, C. Curtis Young, Jr., Robert H. Oswald and Robert Acre were entered.

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Industrial Health Congress Scheduled for Detroit

Dr. Elmer Hess, president of the American Medical Association, and Benson Ford, vice-president of the Ford Motor Company, will be principal speakers at the 16th Annual Congress on Industrial Health. The meeting, sponsored by the Council on Industrial Health, A.M.A.; Wayne County Medical Society, Michigan State Medical Society, Michigan Industrial Medical Association; Detroit Industrial Physicians' Club; and Detroit Society for Surgery of Trauma, will be held in the Sheraton-Cadillac Hotel, Detroit, January 23 and 24, 1956.

Highlights will include a panel on Occupational Medicine in Industrial Relations; Medicine's Responsibilities in the Automotive Age, which will be discussed by Dr. Hess and other national authorities; the annual dinner with Mr. Ford as speaker; and four panel discussions on Absence from Work due to Nonoccupational Illness and Injury.



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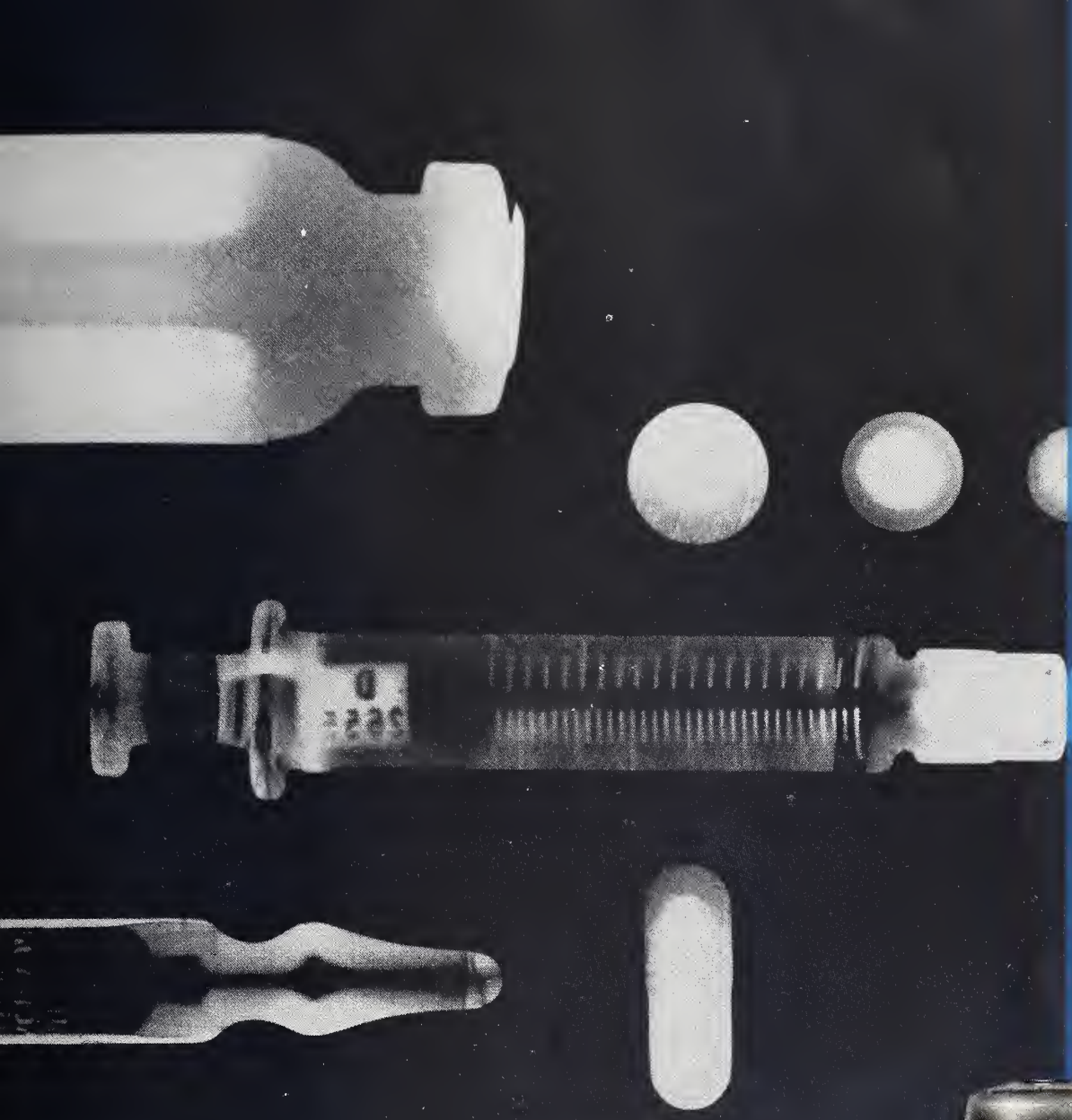
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CT-J-58

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

(French Lick Session, 1955)

Second Meeting

The Council was convened by the chairman immediately following the close of the final session of the House of Delegates. The meeting was held in the Blue Room of the French Lick Sheraton Hotel, Wednesday, October 19.

Roll call showed the following Councilors present: Minor Miller, J. H. Crowder, J. E. Dudding, M. C. Topping, Harry P. Ross, Lester D. Bibler, Guy A. Owsley, Ralph Eades, Elton R. Clarke, Maurice E. Glock, Kenneth L. Olson.

In closed session the Council heard Dwight Murray, A.M.A. President-elect, discuss several matters of importance to organized medicine.

Ballots were distributed and the tellers announced that Dr. Olson had been re-elected as chairman of the Council for the ensuing year.

On motion of Drs. Bibler and Dudding, Dr. James W. Denney was re-elected to another term on the Executive Committee.

On motion of Drs. Owsley and Glock, Dr. E. H. Clauser was re-elected for another term on the Executive Committee.

Discussion was had on attendance at the scientific sessions during the annual meeting. The chairman named Dr. Maurice E. Glock as chairman along with Dr. Lester D. Bibler and Guy A. Owsley as a committee to study attendance at the scientific sessions.

There being no further business the Council adjourned to meet again on Sunday, January 15, 1956, at 10:00 a.m. in the Student Union Building, Indianapolis.

EXECUTIVE COMMITTEE

November 9, 1955

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Elton R. Clarke, M.D.; Kenneth L. Olson, M.D.; O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump and Robert Hollowell, attorneys; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

Guests: W. Burleigh Matthew, M.D.; M. Richard Harding, M.D.; Arthur P. Tiernan.

Membership Report

Number of members November 9, 1955	3,940*
Number of members November 9, 1954	3,886
Gain over last year	54
Number of members December 31, 1954	3,907

* Includes 120 in military service (gratis)

122—$10.00 members (residents and interns)
268—senior members
62—members, dues remitted by Council
2—honorary members

Number who have paid AMA dues:

November, 1955	3,322
November, 1954	3,239
Gain	83

Headquarters Office

The field secretaries reported on their activities since the close of the annual convention, discussing their visits to county societies, the use of recordings, school health conferences, and the interest county societies were showing in following the recommendations of the House of Delegates that they establish county fee schedules.

Statement of Receipts and Expenditures for October for the Association was approved.

Treasurer's Office

On motion of Drs. Olson and Clarke the treasurer and secretary were instructed to set up a student loan fund in the sum of $10,000, the $10,000 to be withdrawn from the General Fund, in accordance with the action of the House of Delegates.

On motion of Drs. Olson and Clauser the legal counsel for the Association was instructed to draw up loan forms for use in making loans to students, the forms to be presented at the next meeting of the committee for approval.

On motion of Drs. Clarke and Olson, George S. Olive and Company is to be employed to audit the books of the Association.

Legislative Matters

The Secretary reviewed the recent meeting called by the American Medical Association to study the proposed amendments to Title II of social security legislation.

Annual Convention, Indianapolis, 1956

On motion of Drs. Clauser and Clarke the dates for the 1956 annual convention were set for Tuesday, Wednesday and Thursday, October 16, 17 and

18. The Executive Committee, the Council and the House of Delegates will meet on Monday, October 15.

Organization Matters

Dr. W. Burleigh Matthew and Dr. M. Richard Harding discussed the recent action of the Section on Ophthalmology and Otolaryngology at the convention just closed in which the Section adopted a resolution advising the withdrawal of the Indiana State Medical Association participation in the Interprofessional Committee on Eye Care. On motion of Drs. Olson and Clarke it was voted that the Association should discontinue its participation in this committee.

Health Science Fairs. The secretary reported on the plans of the American Medical Association to encourage state and component societies to participate in Health Science Fairs. On motion of Drs. Clauser and Olson the Executive Committee endorsed participation in these by the Association and the component societies and requested the appropriate committee to encourage participation at the state and county level and further recommended that the committee be requested to work out a suggested method of state participation in such a program.

A letter from the Indiana Traffic Safety Foundation in which they requested permission to distribute pledge applications through the News Flash was approved by consent, provided the organization is recognized by the Better Business Bureau.

State Chamber of Commerce membership. Upon motion of Drs. Clarke and Clauser membership in the Indiana State Chamber of Commerce was renewed and dues of $100.00 ordered remitted.

Malpractice insurance. A letter from the Vanderburgh County Medical Society relative to the experience of one of their members with malpractice carriers was read and discussed by a representative of the society, Mr. Arthur P. Tiernan, executive secretary, at which time he conveyed the expression of his society that the State Association undertake an intensive study of the malpractice insurance programs being offered Indiana physicians to the end that a solution might be obtained which would be acceptable to the physicians of the state.

A report was presented from the Colorado State Medical Society, together with the opinion of the Colorado State Court, concerning the recent suit for $11,000,000 against the Colorado State Medical Society and others by the Spears Chiropractic Sanitarium in which the court found in favor of the defendants.

A letter was read from Dr. Olson informing the committee that Dr. Elton R. Clarke had resigned as councilor from the Eleventh District inasmuch as he had been elevated to the office of president-elect, and that Dr. Max Adams of Flora would assume the unexpired term as councilor.

The material sent to the Committee by the Indiana Hospital Licensing Council was discussed, and upon motion of Drs. Olson and Clauser the chairman of the Executive Committee was requested to represent the Association at a meeting on November 30.

The secretary reviewed the actions of the House of Delegates, calling attention to the resolutions which were to be sent on to the American Medical Association.

New Business

Material was presented from the Meat Cutters Local No. 167 in which they sought assistance of the Association in obtaining controls on the distribution and sale of poultry in the state of Indiana. By consent this matter was referred to the Legislative Committee.

Advisory Hospital and Health Center Planning Council. By consent the Association was to notify the State Board of Health that they would recommend Dr. Kenneth Olson, Dr. George May and Dr. F. S. Crockett for membership on the Advisory Hospital and Health Center Planning Council.

Dr. Clarke brought up the matter in which he suggested the Veterans Committee study the present contract with the Veterans Administration,

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Careful consideration given to correct shoe fitting as well as padding, braces, bars, wedges, heels, extensions, and corrections. Built-in arches or transferable arches. Also good regular shoes for all the family, men, women, and children.



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with a view toward revising the contract prior to the renewal date in July.

The Journal

Dr. Ramsey reported that at the recent conference conducted by the AMA State Journal Advertising Bureau, of the thirty-three member journals, the Indiana Journal stood third highest in the group.

Report on advertising for December was accepted by consent:

Total, December, 1955	$2,482.20
Total, December, 1954	2,334.08
Net gain	$ 148.12

Future Meetings

By consent the secretary was authorized to participate in the program of the Medical Society Executives Conference at Boston on November 27.

On motion of Drs. Olson and Clauser, Dr. Glen Ward Lee was authorized to represent the Association at the Civil Defense meeting in Chicago November 12 and 13.

There being no further business the Committee adjourned to meet again at 4:00 p. m. daylight saving time, Wednesday, December 14, 1955.

INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

December 7, 1955.

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; Elton R. Clarke, M.D.; Kenneth L. Olson, M.D.; O. W. Sicks, M.D.

Albert Stump, attorney; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

Guests: David Dukes, M.D., and L. C. Lohoff, M.D., Tell City.

Membership Report

Number of members November 30, 1955	3,946*
Number of members November 30, 1954	3,886
Gain over last year	60
Number of members December 31, 1954	3,907

* Includes 120 in military service (gratis)
124—$10.00 members (residents and interns)
268—senior members
62—members, dues remitted by Council
2—honorary members

Number who have paid AMA dues:

December, 1955	3,322
December, 1954	3,239
Gain	83

Headquarters Office

(1) Mr. Bush reported on his activities during the past month and called attention to the fact that in two days during the month of December 140 recordings were made and sent to physicians, and that the total for the year is now 1,000 having been sent to physicians and societies of the state.

(2) Mr. Amick reported on his visits to societies and in detail on the public relations conference held during the AMA meeting at Boston, as well as the county health day sponsored by the Bartholomew-Brown Auxiliary and Society and held at Columbus on November 16.

Legislative Matters

National. A report was given on HR 7225 and the discussion held at various meetings of the American Medical Association, and the secretary was instructed to suggest to the Legislative Committee of the Association that they make an effort to discuss this bill with the senators from Indiana prior to their return to Washington.

The secretary also reported on the resolution adopted by the American Medical Association House of Delegates in which each state was requested to poll their members on the question of inclusion under Social Security. Upon motion of Drs. Clauser and Olson the secretary was instructed to prepare a questionnaire for mailing to the members of the Association on this question.

Statements of Receipts and Expenditures for November for the Association and for October and November for THE JOURNAL were approved.

Organization Matters

A request from the Indiana Academy of General Practice seeking approval of use of the mailing list of the Indiana State Medical Association for addressing invitations to the annual meeting of the Indiana Academy was approved on motion of Drs. Clarke and Olson.

Traffic Safety. Letter from the Indiana Safety Foundation, Inc., inviting the Indiana State Medical Association to participate in a statewide coordinating committee on traffic safety was approved by consent, and the chairman of the Committee on Traffic Safety is to be asked to represent the Association at these meetings.

Student Loan Fund. Mr. Stump reported on the trust agreement prepared to implement the resolution establishing the student loan fund, and the agreement was approved on motion of Drs. Clauser and Clarke, subject to the corrections made by the committee.

The secretary reported further on the proposal of the Meat Cutters Union. This material is to be sent to the Liaison Committee with Labor for discussion with the Labor Union.

A statement from the AMA's Secretary's Letter regarding the efforts to be made to organize a

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Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* tablets

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
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national medical assistants association was read, and the field secretaries were instructed to make inquiry of the societies upon their visits as to their feelings toward county and state organizations of this type.

Mr. Stump informed the committee he had been in contact with the attorney for the State Nurses Association who stated that they had checked with the attorney general on the question of nurses being taught to do venipunctures and had been informed that the action of the Association in not approving this resolution on the basis that the attorney general had ruled it would be illegal was incorrect. This matter is to be re-opened at the January Council meeting for discussion. In the meantime Mr. Stump is to procure an opinion from the attorney general on this question.

Medical Defense. Dr. Olson raised the question about the Association's responsibility in malpractice suits and following discussion the secretary was asked to clarify this through the News Letter or through the appropriate publication of the Association so the members would have knowledge of their ability to procure legal counsel at Association expense. This was approved on motion by Drs. Olson and Clarke.

The secretary informed the committee that he had been invited to participate in a program honoring Dr. C. S. Black at Huntington on December 13. Upon motion of Drs. Clarke and Olson the Association is to purchase suitable flowers for presentation to Dr. Black from the Association.

The Journal

Report on advertising was approved by consent:

Fourth quarter, 1955	$10,667.30
Fourth quarter, 1954	9,050.35
Net gain	$ 1,616.95
Total ads, 1955	$40,044.97
Total ads, 1954	35,579.26
Gain	$ 4,465.71

The advertisement of Lestershire was presented to the committee for approval and by consent THE JOURNAL was instructed to contact again the Cass County Medical Society and if they approved of the operation of this institution, the advertisement could then be inserted.

Inquiry from the State Journal Advertising Bureau regarding the desires of the Association

There being no further business the Committee for accepting advertising from the Wine Institute was discussed and by consent it was agreed that the Association should not accept this advertising. adjourned to meet again at 6:00 p. m. Saturday, January 14, 1956.

The Norbury Sanatorium

Established 1901—Incorporated
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FRANK GARM NORBURY, A.M., M.D., Medical Director
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Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

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Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

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The VICEROY filter tip contains 20,000 tiny filters made exclusively from pure, white cellulose. This is twice as many as the next two largest-selling filter brands.

No wonder VICEROY gives you that fresh, clean, real tobacco taste you miss in other filter brands. No wonder so many doctors now smoke and recommend King-Size VICEROYS.



King-Size Filter Tip **VICEROY**

World's Most Popular Filter Tip Cigarette
Only a Penny or Two More
Than Cigarettes Without Filters

News from the County Societies

Fort Wayne (Allen County) Medical Society members attended the December 6 Road Show of the Indiana Academy of General Practice as their December scientific session. The meeting was held in the Fort Wayne Chamber of Commerce with 120 physicians present. A social hour and buffet supper were enjoyed between the afternoon and evening programs.

Guest speakers were Dr. Sprague H. Gardiner, assistant professor of obstetrics and gynecology at the Indiana University School of Medicine, and Dr. Donald A. Covalt, associate director of the New York Institute of Rehabilitation.

Dr. Gardiner presented the first paper, "Cancer of the Reproductive System in the Female", and was followed by Dr. Covalt who spoke on "Recent Developments in Cardiac Rehabilitation".

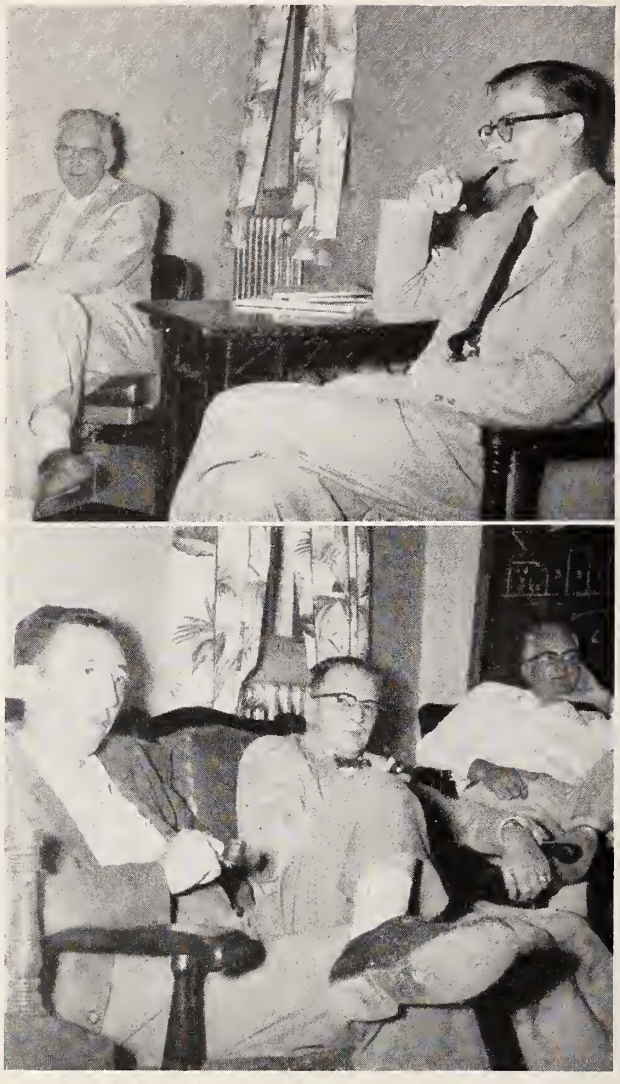
Dr. Gardiner also presented the first paper on the evening program when his topic was "Sterility Aspects of Obstetrics". Dr. Covalt's second discussion was on "The Overall Picture of Rehabilitation As Far as the Medical Field is Concerned".

Thirty members of **Bartholomew-Brown County Medical Society** met in the Harrison Lake Country Club November 9 when their program consisted of a symposium on industrial health. A panel of industrial personnel officers discussed the general topic and mutual problems were covered by panelists and members. Insurance coverage, accidents, sick leave, filling out of forms and the importance of accurate reports were discussed.

"Principles of Fracture Reduction" was the film viewed by **Boone County Medical Society** members in Witham Memorial Hospital, Lebanon, at an evening meeting December 6. Eleven members attended.

The next meeting of the society was scheduled for the same place on January 3.

Carroll County Medical Society members met November 16 in the Sportsman's Club, Monticello, for dinner and a business session. They were joined by the county health nurse and several physicians' wives. Seven members were present.



Boone County doctors are pictured at a September meeting in Lebanon. Top photograph shows Dr. Clarence G. Kern and Dr. Jack Porter, both of Lebanon. Lower picture is of Dr. Lawrence S. Bailey, Zionsville; Dr. Alvin D. Schaaf, Jamestown; and Dr. Robert H. Wisehart, Lebanon.

They approved the tuberculosis patch testing program for school children as endorsed by the Indiana Tuberculosis Association; adopted a plan for medical examinations for doctors similar to that recently conducted in Tippecanoe county; discussed the district meeting which will be held on May 16, 1956 in Delphi; talked of liaison problems with other organizations; voted to fol-

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*Schaefer, F. H.: Ohio State M. J. 51:347 (April) 1955.



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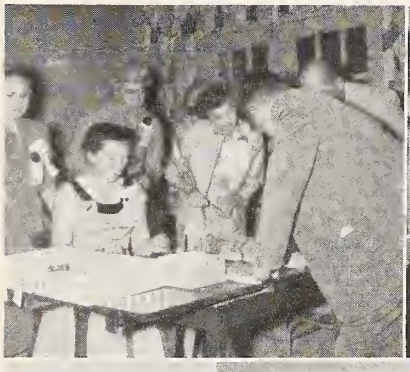
PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

low a plan in giving polio shots which would preclude the waste of vaccine; and concluded their meeting with discussion of tape recordings and films and current magazine articles.

About 50 physicians and members of the Auxiliary of **Cass County Medical Society** held a dinner meeting November 21 in the Ben Hur Motel dining room near Logansport.

Dr. Philip W. Rothrock, Lafayette, discussed "Stop Rheumatic Fever" before the two groups. The talk was presented as a part of the Indiana Heart Foundation's current project.

A brief business meeting preceded the scientific talk. Kenneth W. Bush, ISMA field secretary, presented a report from headquarters on several legislative matters.









Clinton County Medical Society members and the staff of Clinton County Hospital, Frankfort, met in the hospital November 15 for dinner and separate business meetings. Fifteen doctors attended and Kenneth W. Bush, ISMA field secretary, was a guest. He spoke briefly pertaining to field service, headquarters office details and resolutions adopted by the House of Delegates at French Lick. Dr. C. W. Holmes, Frankfort, delegate, also discussed the annual convention proceedings.

The **Daviess-Martin County Medical Society** held a staff meeting at the Daviess County Hospital December 5 with 14 members present. Staff officers were elected, news releases concerning polio inoculations were approved, and the meeting was concluded by a report by Robert J. Amick, field secretary, on action of the House of Delegates at the A.M.A. Boston session.

A tentative program for the May 2 district meeting was discussed at the **Dearborn-Ohio Medical Society** meeting November 17 in the

Photographs taken at the **11th District meeting** September 21 in Logansport Country Club show, upper left, Mrs. L. J. Hillis, Mrs. R. J. Morrical, Mrs. D. K. Winter, Mrs. B. R. Hall, Dr. L. J. Hillis and Dr. R. J. Morrical (front of table); right, Dr. Claude S. Black, Warren, and Dr. Charles C. Crampton, Delphi, charter members. Center left, Dr. T. W. Omstead, Huntington, district president; right, Drs. E. W. Bailey and D. K. Winter, Logansport; Owen Johnson, Peru; Fred R. Malott, Converse; Charles L. Wise, Camden; Elton R. Clarke, Kokomo; and Walter L. Portteus, Franklin.
Bottom views show Cass County talent performing for district meeting. Dr. Winter leads orchestra, Mrs. Hall, Mrs. Winter and Mrs. Bailey, do a Maguire Sisters act; and Dr. Winter directs Dr. E. Camille Killian, soloist (all in pantomime).









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Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

Dearborn Country Club. Thirteen attended the dinner meeting. During the business meeting R. J. Amick, field secretary, reported on several matters pertaining to the action of the ISMA House of Delegates, and to pending national legislation.

A film, "The Management of Streptococcal Infections and Their Complications" was shown B. E. Kitch, Wyeth representative.

Decatur County Medical Society met November 15 in the Decatur County Memorial Hospital in Greensburg when nine members and one guest were present for luncheon. A representative of Blue Cross and the ISMA field secretary both spoke briefly, presenting reports of recent developments and outlining services available to members of the profession.

Dr. Charles Overpeck, Greensburg, was the speaker. He presented a paper on "Retrolental Fibroplasia".

Fifty-four members of **Delaware-Blackford County Medical Society** attended the annual meeting and election of officers November 15. Officers for 1956 will be: President, Dr. Wendell Covalt; president-elect, Dr. Anson G. Hurley; secretary, Dr. Francis E. Stout; treasurer, Dr. Phillip Ball, all of Muncie.

Lengthy discussion followed on participation in the Civil Defense program at the county level; on recommendations made by the Liaison Committee with Labor of ISMA; and on a number of Blue Shield matters. The report of delegates to the ISMA House of Delegates annual meeting was delayed until the next regular meeting.

The committee on arrangements for the Christmas party announced that affair was to be held in the Green Hills Country Club on December 13.

The **Floyd County Medical Society** met October 14 in the New Albany Country Club for dinner and a combined business and scientific meeting. Plans were made for the Christmas party which was to be held December 10 in conjunction with the Floyd County Pharmaceutical Association.

A general discussion of the advisability of routine chest X-ray examinations for all hospital admissions resulted in the naming of a special committee to cooperate with the standing committee on tuberculosis to investigate possibility of expanding the program of examinations. Plans to better relations with the welfare department were discussed and a rotating committee of three doctors will check all claims submitted to the welfare department. Salk vaccine inoculation problems were discussed and a committee appointed to study the question of indigency.

A paper on the "Complications of Anesthesia" was presented by Dr. Asche, Louisville.

Twenty-one members of the society met for the November 11 dinner meeting in the New Albany Country Club. Dr. John Paris gave a detailed report on the action of the ISMA House of Delegates and the society voted to purchase the film which was shown, "A Doctor Examines the Heart", for showing before lay groups. A committee was appointed to contact lay organizations to inform them of the availability of Floyd county doctors for talks and the showing of educational films before such organizations. Nominations for officers were made.

Dr. J. Guy Hoover, Evansville, presented a paper on "Intestinal Obstructions" at the meeting of the **Gibson County Medical Society** November 9 in the Emerson Hotel, Princeton. Twelve members attended. The society planned to meet December 7 at the same time and place.

Henry County Medical Society members heard Dr. A. L. Marshall, Indiana State Board of Health, discuss communicable diseases at an evening meeting November 17 in the Henry County Hospital, New Castle. Eighteen members and one guest attended the meeting. A committee was named to discuss with members resolutions adopted by the House of Delegates at the recent annual convention of Indiana State Medical Association. The annual dinner was to be held December 15 in the New Castle Country Club.

Dr. William D. Scharbrough, Medora, will serve as president of both the **Jackson County Medical Society** and the Schneck Memorial Hospital during the coming year. His election took place at annual meetings of both groups

December 1 in the Elks' Club, Seymour. Other officers of the society will be Dr. Kenneth Bobb, Seymour, vice-president; and Dr. G. H. Kamman, Seymour, who was reelected secretary-treasurer. He has served many years in that office. Dr. Jack Shields, Brownstown, was re-elected delegate to ISMA.

Dr. Harold E. Miller, retiring president, was in charge of the meeting which followed dinner in the club. Dr. Kamman gave a complete report of activities of the society during 1955.

Knox County Medical Society members heard two surgeons and two attorneys discuss in a symposium "Industrial Low Back Pains". The meeting was held November 15 in Vincennes. Guest physicians from several cities joined the members to hear Dr. William C. Fisher, neurosurgeon, and Dr. Willis L. Pugh, orthopedic surgeon, discuss the medical aspect of such injury cases, and Attorneys Bamberger and McCrae, all of Evansville, present the legal problems involved.

Members of **LaPorte County Medical Society** have joined members of Lake, Porter, Starke, Marshall and St. Joseph as sponsors of the National Science Fair in April. The program will be presented at Valparaiso high school. Several local problems and insurance plans were also discussed at the November 17 meeting held in Michigan City. Drs. G. O. Larson and Daniel G. Bernoske, delegates to ISMA, gave reports of the proceedings of the annual convention. Plans were also made for the Christmas party which was to be held at Pottawattomie Country Club December 15.

A report by the field secretary of action of the House of Delegates at the A.M.A. Boston meeting furnished the program for **Lawrence**





Relaxing at the First District meeting in Princeton September 15 are Drs. A. L. Woods, Poseyville; W. C. Stover, Boonville; and O. T. Brazleton, Princeton. Lower right, Dr. W. L. Pugh, Evansville, and Dr. Julian Present, Evansville, question a representative of Miller's Gun Shop, center, concerning his display.

Golfers take advantage of warm fall day at First District meeting. Left to right, Drs. Peck, Turner, Lawrence and Present.









County Medical Society when 22 members met for luncheon in the Dunn Memorial Hospital, Bedford, on December 7.

Dr. Clyde G. Culbertson, Indianapolis, director of biological research for Eli Lilly and Company, spoke on "Immunology" at the meeting of **Miami County Medical Society** November 25 in Veach's Steak House, Peru. Twelve members were present to hear Dr. Culbertson discuss immunizations, with special emphasis on those for poliomyelitis, rabies and tetanus. Report of the meeting indicated the talk was highly informative and interesting.

A discussion of several problems resulted in the appointment of two special study committees. Kenneth W. Bush, field secretary, presented an outline of some state and national level matters.

Twenty-six members of **Montgomery County Medical Society** attended a dinner meeting in the Crawfordsville Country Club November 17. A short business meeting was held with Dr. Wemple Dodds, district councilor, outlining some plans for study by the members.

Dr. Richard Gripe, Lafayette, spoke on the Indiana Heart Foundation's rheumatic fever control program.

Orange County Medical Society met December 6 at Spring Mill State Park for a dinner meeting with nine present.

The film "Management of Streptococcal Infections and Complications" shown by B. E. Kitch of Wyeth furnished the scientific portion of the program. During the business meeting R. J. Amick, field secretary, reported on the A.M.A. meeting in Boston. A roundtable discussion of the project to establish a county hospital followed. Members of the society are represented by a committee under the chairmanship of Dr. Ivan A. Clark, Paoli, which is working with the civic steering committee to raise funds for a county hospital. Plans for the proposed $875,000 structure include raising the first third of the amount by July 1, 1956 by public subscription, securing one-third through the Hill-Burton federal fund, and obtaining the remainder through a county bond issue.

Officers for 1956 were elected by members of **Owen-Monroe County Medical Society** at their meeting December 1 in the Bloomington Country Club. The election was held following dinner. Twenty-three members selected Drs. G. W. Poolitson, Bloomington, for president; C. W. Stouder, Gosport, vice-president; B. A. Spencer, Bloomington, treasurer; A. C. Estes, Bloomington, executive board member; and W. C. Reed, Bloomington, and Donald Blackwell, Spencer, delegates.

The next meeting will be held January 26 at 7 p.m. in the Bloomington Country Club.

The **Parke-Vermillion County Medical Society** met November 16 for dinner in the Vermillion County Hospital, Clinton, with 12 members present. During the business meeting, R. J. Amick, field secretary, discussed legislation and members heard and discussed several communications from ISMA state headquarters. Dr. Jack G. Weinbaum, Terre Haute, presented a paper on "The Pathologist and General Practitioner as a Team."

Dr. W. J. Fuson, Greencastle, was elected president of **Putnam County Medical Society** at the annual meeting December 9 in the DePauw Union Building. Dr. W. R. Tipton, Greencastle, was elected vice-president; and Dr. Anne S. Nichols, Greencastle, will serve as secretary-treasurer during 1956.

Sixteen members attended the dinner meeting and will meet at the same place at 6:30 p.m., January 13.

A comprehensive report of the action of the I.S.M.A. House of Delegates by Dr. J. E. Alexander was presented to the **Vanderburgh County Medical Society** November 15 when 75 members met in the McCurdy Hotel for dinner.

The scientific program was presented by Dr. Richard Nay, Indianapolis, chairman of the Indiana Heart Foundation's Rheumatic Fever committee.

The **Wells County Medical Society** met November 21 in the Bluffton Community building to hear Dr. C. William Goebel, Fort Wayne, discuss "Rheumatic Fever Control".

During the brief business meeting, the 15 members present, appointed a study committee to prepare a county fee schedule. The Christmas party of the society and Auxiliary was held at the Dutch Mill, Bluffton, with Mrs. Richard P. Yoder and Mrs. Robert Johnston as co-hostesses.







Randolph County physicians are shown at their first fall meeting at Union City Country Club. Top, left to right, Drs. Paul W. Sparks, C. W. Hannah, W. S. Dininger, all of Winchester; B. D. Wagoner, Union City; and Howard W. Koch, Winchester. Bottom, Drs. H. E. White, Farmland, John S. Robison, Winchester; C. R. Slick, Lynn; R. B. Engle, Winchester, and Richard M. Potter, Ridgeville.

Photos at right were taken at summer meeting of **Tippecanoe County Medical Society.** Top, Drs. Jack A. Bush, West Lafayette; R. E. Williams, J. M. McFadden, L. R. Johnson, R. C. McAdams, and W. M. Sholty, all of Lafayette. Lower photo, Drs. K. F. Laws, F. W. Ratcliff, Catherine M. Balkema, Bertha Rose Carroll, and Robert C. Bolin.

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Indiana University School of Medicine Announces 10 Postgraduate Courses

MEMBERS OF THE POSTGRADUATE COMMITTEE at the Indiana University Medical Center plan to present 10 postgraduate courses at the university during the first five months of 1956. Dr. Don E. Wood, Indianapolis, is chairman of the committee.

Definite dates have been set for the following courses:

February 15, 1956 — **HEART SYMPOSIUM**

The Fifth Annual Heart Symposium will be a series of panels on the various phases of the treatment of heart disease.

February 27-29 — **COURSE IN ELECTROCARDIOGRAPHY**

This course is designed to review basic concepts of electrocardiography incorporating the newer leads and their interpretations. Although designed primarily as a basic course, some preliminary knowledge of electrocardiography would be highly desirable. Fee: $30.00; limit 30; $10.00 deposit with registration.

March 7 — **NEUROLOGY AND NEUROSURGERY**

A course lasting from 1:00 p.m. to 9:00 p.m. covering the technique and interpretation of the neurological examination; the diagnosis, pathology and treatment of the apoplexies; the neurosurgical correction of conditions leading to mental deficiency; and the diagnosis, electroencephalogram and treatment of convulsive disorders.

March 19-31 — **CLINICAL AND ANATOMICAL COURSE IN OTORHINOLARYNGOLOGY**

This is primarily an intensive course in anatomy of the head and neck with emphasis on surgical anatomy of this region. The course will be restricted to physicians specializing in E.N.T. and residents in training for this specialty. Fee: $250.00.

March 27-28 — **CANCER SYMPOSIUM ON INTRACRANIAL NEOPLASMS**

An outstanding program dealing with the pathology, clinical diagnosis, x-ray diagnosis, and newer diagnostic techniques as well as means of treatment of intracranial neoplasms has been arranged for this Ninth Annual Postgraduate Symposium on Malignancy. Many world famed authorities on this subject will be the primary discussants.

April 18 — **SYMPOSIUM ON TRAUMA**

A review of basic principles and recent developments in the surgical management of trauma. Greatest emphasis is placed on the types of injuries seen commonly in rural as well as urban practice. The emergency surgical treatment of vascular, abdominal, chest and nervous system injuries will be discussed.

May 21-22 — **COURSE IN CLINICAL CARDIOLOGY**

A two-day course on Rheumatic Heart Disease and Arteriosclerotic Heart Disease. The course is designed to emphasize basic concepts as a background for modern diagnosis and therapy.

Three other postgraduate courses have been scheduled; one is a continuing program, and dates for the remaining two will be announced soon.

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POSTGRADUATE COURSE ON THE ANEMIAS

An afternoon program designed to cover the diagnosis and treatment of various types of anemias. Special problems of anemia relating to surgery, obstetrics, pediatrics and other special fields will be discussed. This course has a $10.00 registration fee and is limited to 20 physicians. A definite date has not been set as yet and further information will be published later.

COURSE IN LUNG DISEASES AND PULMONARY FUNCTION

This course is designed to acquaint the practicing physician with the now commonly performed pulmonary tests and to emphasize their value in the practice of medicine particularly as they apply in the explanation of the pathologic physiology of the commonly encountered chest diseases.

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of the INDIANA STATE MEDICAL ASSOCIATION

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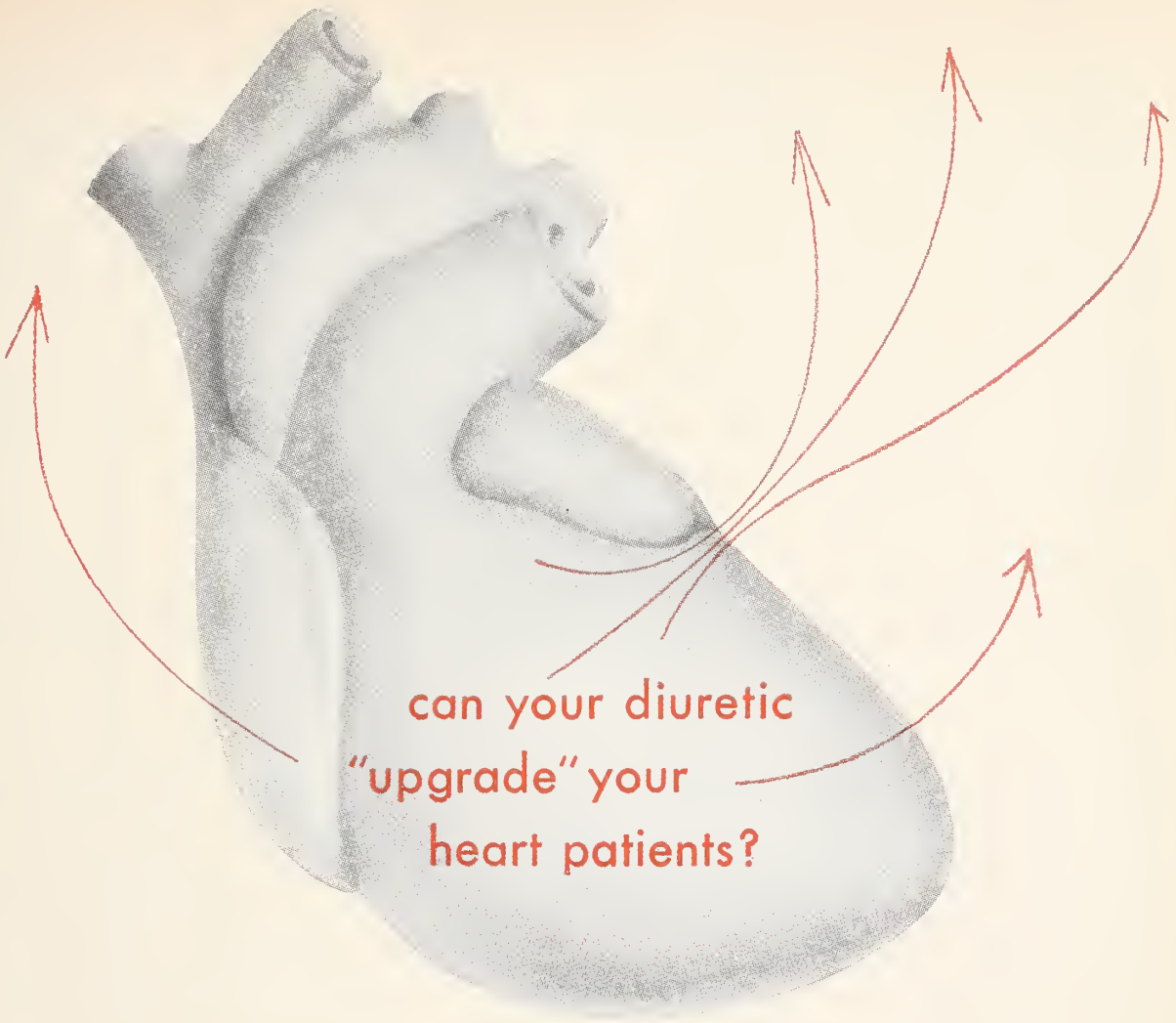
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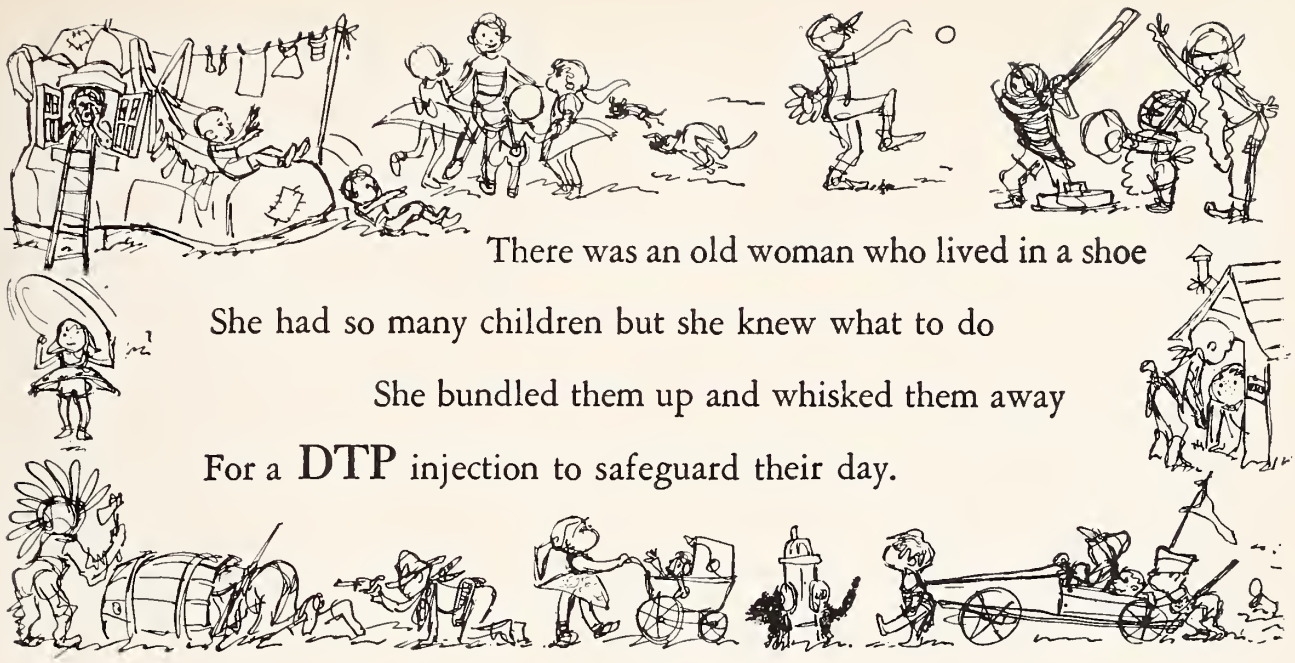
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5.	C. M. Schauwecker, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Greencastle, June 6, 1956
6.	William R. Tindall, M.D., Shelbyville	H. N. Smith, M.D., Brookville	Richmond, April 12, 1956
7.	Joseph F. Ferrara, M.D., Franklin	Arthur W. Records, M.D., Franklin	Indianapolis, May, 1956
8.	Roger R. Reed, M.D., Anderson	Warren E. Fischer, M.D., Anderson	Anderson, May 9, 1956
9.	J. A. Van Kirk, M.D., Frankfort	Frank A. Beardsley, M.D., Frankfort	Frankfort, May 24, 1956
10.	H. M. Baitinger, M.D., Gary	S. J. Brady, M.D., Gary	
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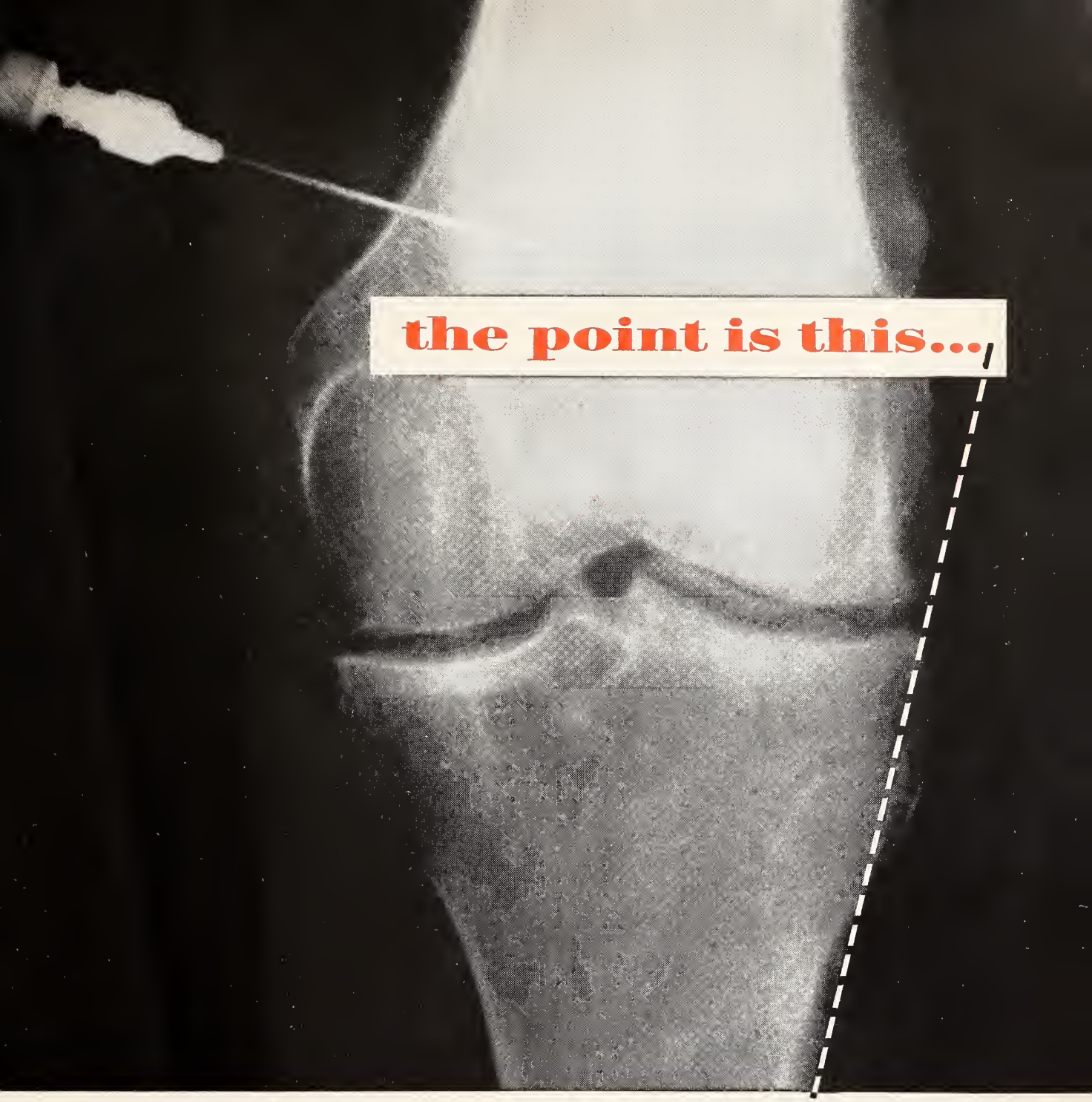
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1. Moyer, J.H., in discussion of Galen, W.P., and Duke, J.F.: Outpatient Treatment of Hypertension with Hexamethonium and Hydralazine, South. M.J. *47*:858 (Sept.) 1954.

2. Moyer, J.H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

3. Wilkins, R.W.; Stanton, J.R., and Freis, E.D.: Essential Hypertension. Therapeutic Trial of Veriloid, a New Extract of Veratrum viride, Proc. Soc. Exper. Biol. & Med. *72*:302 (Nov.) 1949.

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Riker

LOS ANGELES

Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

specific against coccic infections

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

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with little risk of serious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN (100 and 250 mg.), bottles of 25 and 100. Abbott

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Medical Panorama—

A. W. Cavins, M. D.

Associate Editor

COMPLETE VS. INCOMPLETE EXAMINATION or THE EYES HAVE IT

A signed editorial appears in *The Journal of the South Carolina Medical Association* for December, 1955, which we think rates reprinting in full. Furthermore, if there were some way to get the gist of it across to our patients, much good could come of it. Probably the only way to call this matter to the attention of the public is for the family doctor (and specialists, too) to do it in a personal and professional manner. Here is the editorial:

EYE CARE

A national campaign of advertising is being carried on by an organization known as the Better Vision Institute. Great emphasis is laid on the matter of regular testing of the eyes. Absolutely no effort is made to distinguish those who are qualified to examine eyes for the presence or absence of disease from those who merely test for visual acuity and prescribe glasses. This is apparently an effort to sell glasses, and the implication is made that if glasses are prescribed or occasionally changed, the eyes are receiving the proper and necessary care. Nothing could be farther from the truth.

Only the medically trained practitioner, the ophthalmologist, is capable of diagnosing and treating diseases of the eye. Only the eye physician can recognize early glaucoma and sometimes prevent irrevocable injury to eyesight. Month after month, year after year, hapless individuals are seen who, believing that they are getting proper attention, go to the optometrist to get glasses. Few of these patients are ever referred for medical care and turn up in the opthalmologist's office only when they recognize their mistake, and only too often when it is too late to do anything for them. Our public welfare rolls are strewn with cases blind from eye disease, many of whom could have been saved their sight if they had been seen at the proper time and handled intelligently. It is estimated that three percent of persons over forty years of age become afflicted with glaucoma which only too often comes without pain or sufficient central visual loss to cause alarm until it is too late.

Ophthalmology realizes that there is a definite place for optometry. There are simply not enough ophthalmologists available to provide the glasses necessary for the effectiveness and the comfort of the public. Many, if not most, ophthalmologists would be very glad to be relieved of what to a great many is the tedium of refraction. However, refraction is certainly part of a complete eye examination, and many people prefer a complete and thorough eye examination. The ophthalmologist is the only person who can render such a service. Therefore, he does refraction and he should do it better than anyone else, since he has not only physical but also pharmacological aids at his command. The latter are often indispensable, and their use is wisely permitted by law only to the medically trained.

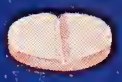
Our State of South Carolina is to be commended for allowing the sale of spectacles over the dime store counters and elsewhere. It is infinitely safer to have a person obtain glasses under circumstances where he knows that he is not getting eye care, than to have him go for glasses to one who is not a physician, and is often quite willing to foster an illusion he has created by allowing himself to be called doctor. There is no known record of anyone having been harmed by a dime store glass, nor by any other glass. True, the patient may not be comfortable but, in that case, he will not wear his glass; and, in any case (the cross-eyed child alone excepted), the matter of wearing glasses, which are merely crutches, is concerned solely with the satisfaction and pleasure of the wearer.

In the past few years, actually millions of dollars have been spent on advertising and furthering the work of the Better Vision Institute. Even though the professional gap between ophthalmology and optometry is wide, these two groups, with opticians and manufacturers of optical goods, could and should agree on a program which has for its purpose the dissemination of truth for the betterment of the public health.

The concept concerning "dime store" spectacles is a little unusual, but the point concerning the sense of false security likely to be engendered by optometry alone (without a complete eye examination) is well taken, and the author thereby justified. Incomplete examination is bad medicine in any branch of our profession.

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for more precise dosage

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Both forms of Baker's Modified Milk are supplied gratis to all hospitals for your use.

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20 calories per ounce

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Powder form—1 Tbsp. powder to 2 fl. oz. of water.

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REFERENCES: 1. Boland, E. W. and Headley, N. E., *J.A.M.A.* **148**:981, March 22, 1952. 2. Ward, L. E., Polley, H. F., Slocumb, C. H. and Hench, P. S., *J.A.M.A.* **152**:119, May 9, 1953. 3. Snow, W. B. and Coss, J. A., *N.Y. State J. Med.* **52**:319, Feb. 1, 1952.

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The Eighth Annual American Academy of General Practice Scientific Assembly March 19-22 is expected to attract more than 5,000 general practitioners to Washington, D. C., where the four-day meeting will be held in the Armory.

The Academy's Congress of Delegates will convene March 17 in the Hotel Statler where sessions of the Congress and many social functions will be held. The scientific program, with 26 speakers, will be presented in the Armory where there will be 60 scientific displays and 250 technical exhibits.

Highlights of the program include two live clinics, a symposium on obstetrics and an address by Surgeon General Leonard Scheele. Tours through the National Institutes of Health at Bethesda have been arranged.

The President's reception and dance will be held on March 21.

Several affairs have been arranged for the entertainment of doctors' wives and children.

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Each FULL-STRENGTH tablet contains:

Phenobarbital..... 15.0 mg. (¼ gr.)
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Dosage:

One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.

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Phenobarbital..... 8.0 mg. (⅛ gr.)
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Dosage:

While the dosage and indications are the same as for the full-strength tablets, this tablet allows greater flexibility in regulating the individual dose, and may be employed in less severe gastrointestinal conditions.

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Both strengths in bottles of 100 tablets.

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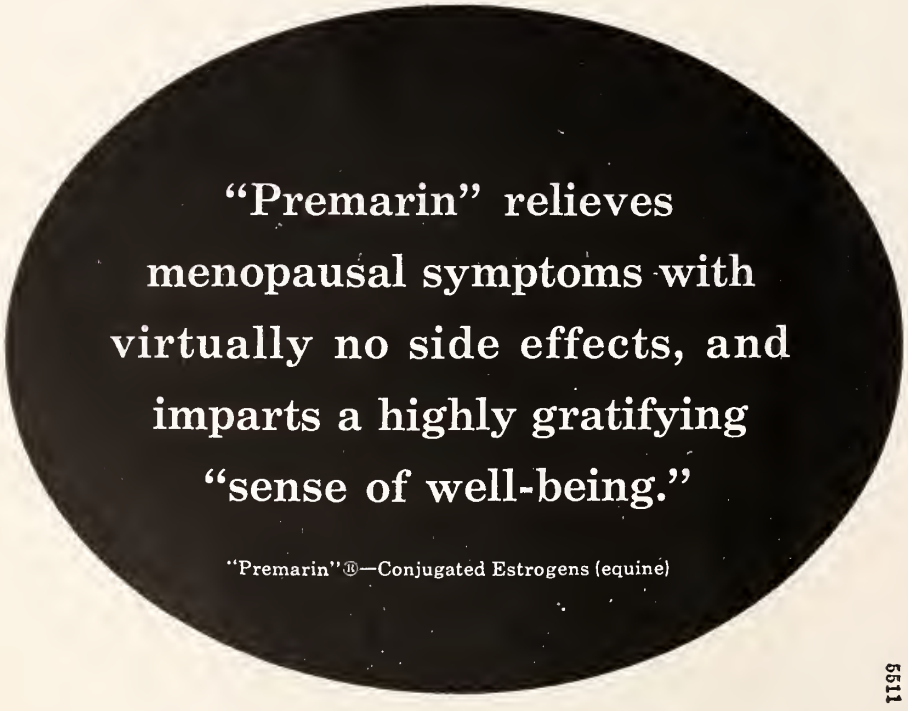
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Occupational Medicine Meeting Planned for Cincinnati

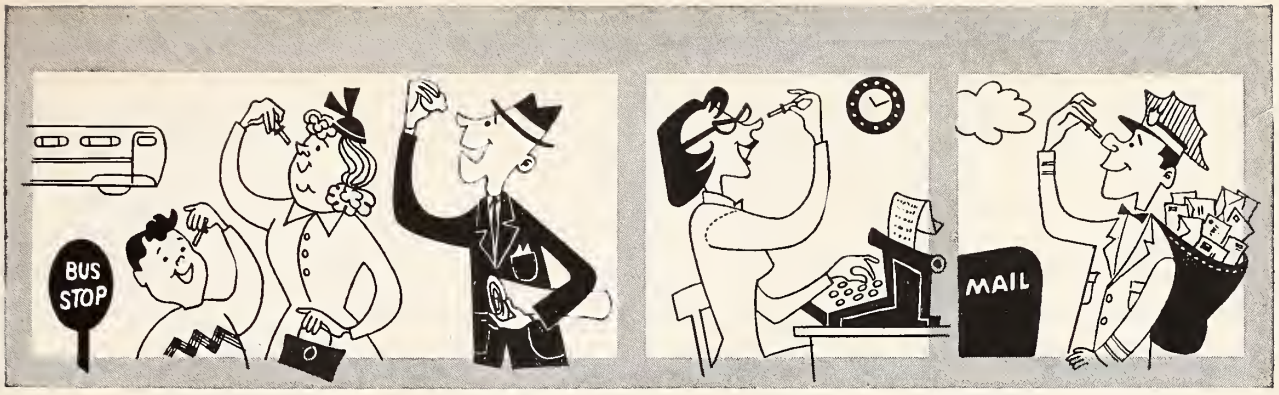
The American Academy of Occupational Medicine has announced that it will hold its eighth annual meeting at the Netherland-Plaza Hotel, Cincinnati, on February 15, 16, and 17.

A varied program of interest to physicians concerned with occupational medicine has been planned and an invitation to attend is extended to all physicians in the area surrounding Cincinnati. There will be no registration fee.

Those who are interested are asked to communicate with the program chairman, Dr. Joseph A. Quigley, National Lead Company, P. O. Box 158, Mt. Healthy Station, Cincinnati 31, Ohio; or with Dr. Leonard J. Goldwater, Secretary, 600 West 168th Street, New York 32, New York.



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Fifth Annual Heart Symposium, February 15, Offers Three Major Topics

SPONSORED by the Indiana University School of Medicine and the Indiana Heart Foundation, the Fifth Annual Heart Symposium will be presented in the Auditorium, School of Medicine, 1100 West Michigan Street, Indianapolis, on February 15 between 3 and 9 p. m.

The official program follows:

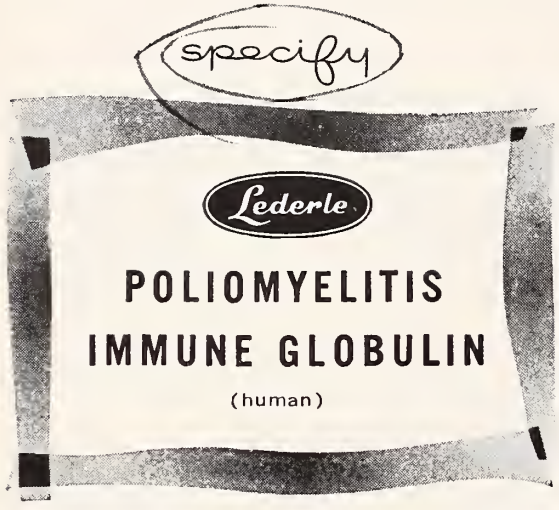
PANEL DISCUSSIONS

(E.S.T.)

3-4 p.m. *Treatment of Rheumatic Fever and Cardiac Complications*
- Chairman: Dr. Keith Hammond, Paoli
- Dr. Richard Nay, Indianapolis
- Dr. Harris B. Shumacker, Indianapolis
- Dr. Thomas O. Middleton, Bloomington
- Dr. Walter F. Kammer, Muncie

4-5 p.m. *Treatment of Coronary Heart Disease*
- Chairman: Dr. Charles Fisch, Indianapolis
- Dr. Maurice M. Best, Louisville, Ky.
- Dr. John F. Ling, Richmond
- Dr. Dan L. Urschel, Mentone
- (Dinner may be obtained at the Cafeteria, Student Union)

7:30 p.m. *Treatment of Hypertension*
- Chairman: Dr. J. O. Ritchey, Indianapolis
- Dr. Philip W. Rothrock, Lafayette
- Dr. B. L. Martz, Indianapolis
- Dr. Walter Judson, Toledo, Ohio
- Dr. Gordon T. Herrmann, Evansville



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THE MONTH IN WASHINGTON

Washington, D. C.—Bills that have been hanging fire in Senate and House Committees for over a year finally are getting attention as the Administration pushes its program for broader and more uniform medical care for the families of servicemen.

A new version of a bill was dropped in the hopper on the opening day of this session by Chairman Carl Vinson of the House Armed Services Committee. It was designed in part to supply answers to a number of questions growing out of earlier versions sponsored by the Defense Department. Actually it raised more questions, which only hearings and testimony from expert witnesses and debate on the floor of Congress can answer.

The bill (H.R. 7994) authorizes, as a matter of right, broad medical care for dependents of the armed forces as well as of Coast Guard, Public Health Service and Coast and Geodetic Survey personnel serving on active duty. (The bill would authorize health insurance only for dependents of last three services.) Separate bills have been introduced in the past providing medical care for dependents of Coast Guard, PHS and Geodetic Survey, but this marks the first time they are brought into the same bill with military personnel.

In provision of services, the bill has no surprises over its predecessors. It calls for diagnosis, treatment of acute medical and surgical conditions, treatment of contagious diseases, and maternity and infant care.

MANY FEATURES CHANGED

On another point of major interest to physicians, *the bill drops out all mention of the hometown medical care plan*, which was a part of Mr. Vinson's earlier bill. That bill contemplated use of civilian hospitals and doctors for those dependents who were not near military medical facilities and who had not taken out health insurance, with the government paying part of the cost.

Another area of almost certain debate in the latest bill is the insurance features. There are these main points:

1. A serviceman may elect to rely entirely on the chance of finding space available in a military hospital or clinic for his family, or he may choose protection through an insurance plan.

2. The family deciding on insurance has its choice of going to a military hospital or using civilian resources. The uninsured family could be charged by the military for out-patient care, and would have to pay subsistence costs while in the hospital.

3. A serviceman taking insurance would pay 30% of monthly premiums for a basic plan covering his wife and children, and the entire premiums for coverage of dependent parents and

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parents-in-law. Parents and parents-in-law who found space in a military hospital, however, would be admitted on the same basis as wives and children.

4. Catastrophic-type coverage, at additional premium.

5. To take care of long term illnesses, the bill provides for transfer of dependents to military facilities once they have used up benefits in an insurance plan. Or if such transfer isn't feasible, the government could pay the additional costs for private care.

INSURANCE SURVEY INCOMPLETE

The bill was introduced before the Defense Department had completed a survey of Blue Shield, Blue Cross and commercial plans to determine to what extent they could provide care under the bill. Conceivably the survey could further change the shape of an already much-revised piece of legislation.

President Eisenhower in his State of the Union message summed up the case for dependent medical care this way: "Much has been done to attract and hold capable military personnel, but more needs to be done." He also broadly outlined administration plans in the health field, with emphasis on more money for research and federal aid to medical schools and to private research facilities for construction. With bipartisan bills along this line already before Congress, these proposals may move right along before adjournment in mid-summer.

However, Congress might decide that for this year medical schools should settle for the $90 million of Ford Foundation money being made available to private schools to help strengthen teaching staffs.

By the same token, there was some question just how much Congress would vote for Hill-Burton hospital programs this session in the light of the $200 million Ford grants to some 3,500 non-profit hospitals.

A recent Public Health Service report indicates that states are now showing less preference for "public" Salk vaccine programs than they did a few months ago. The sixth allotment marked the high-point in "public" preference. Then came a slight but steady decline.

Clinical Reviews

MAYO CLINIC AND MAYO FOUNDATION
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This 3-day program will be devoted to lectures and discussions on problems of current interest in general medicine and surgery. The presentations will be made by staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

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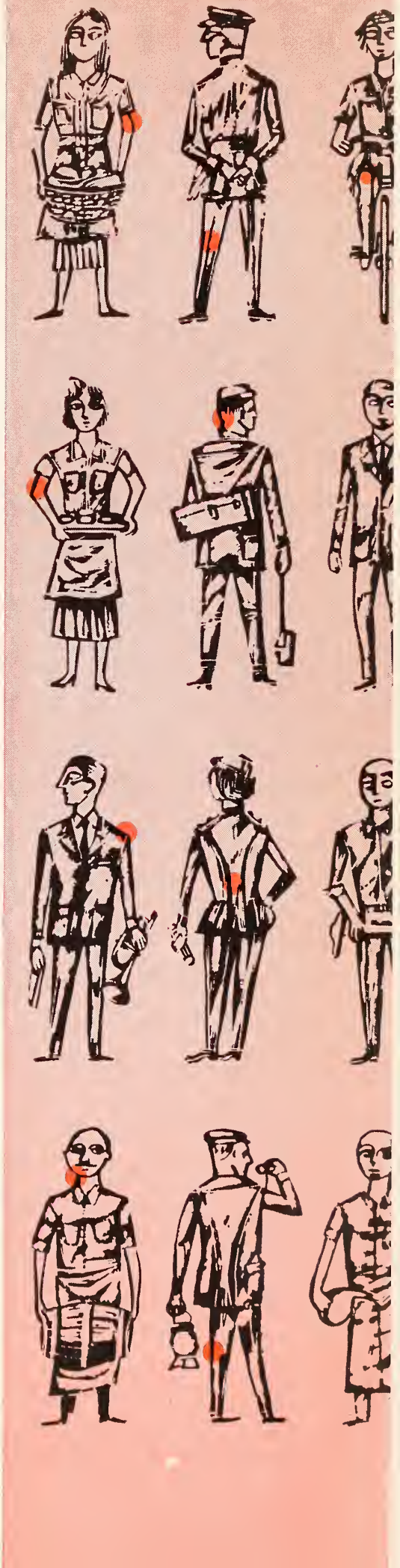
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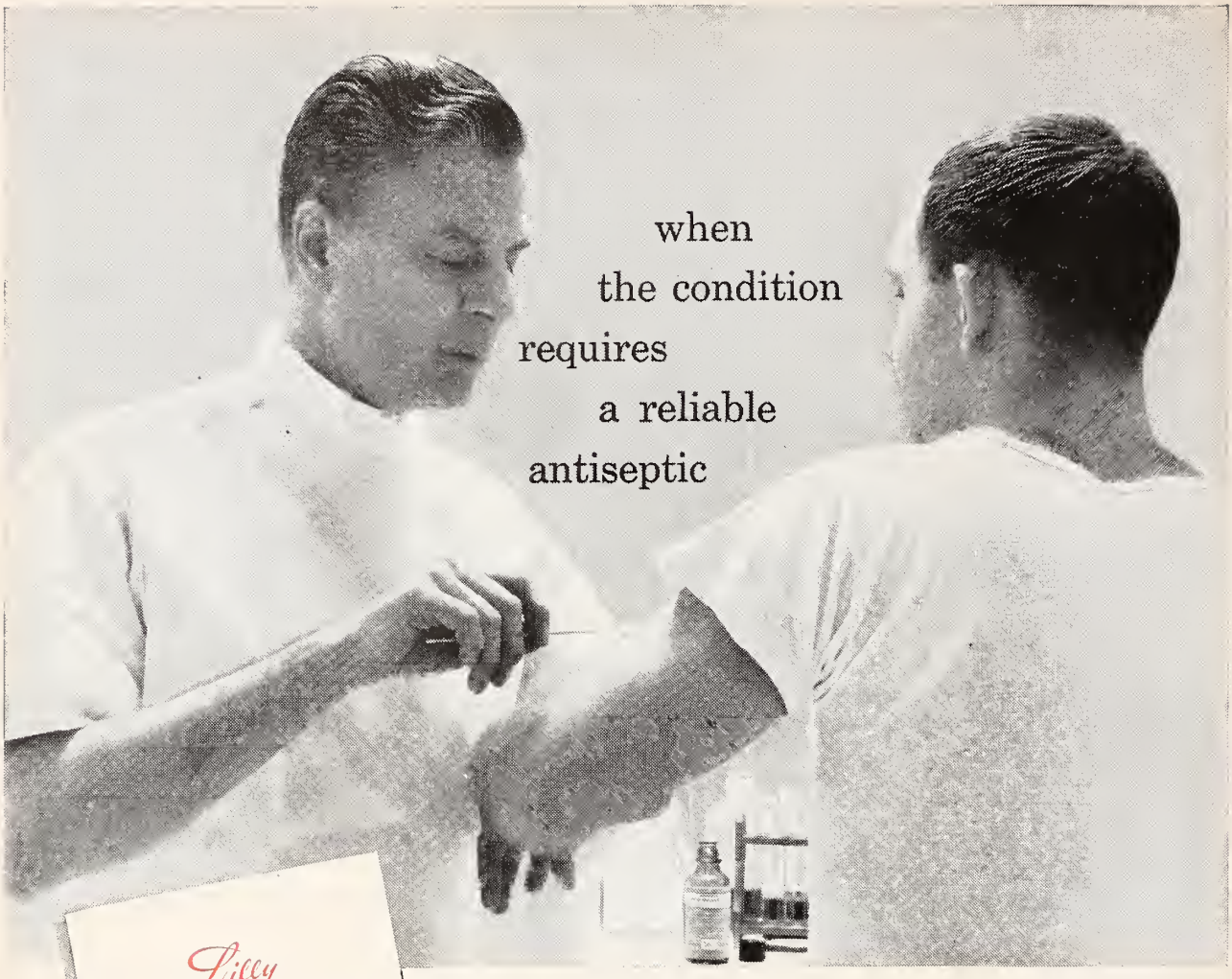
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 49 — February 1956 — Number 2

The Robert Moore Heart Clinic

AN INTRODUCTION

KENNETH G. KOHLSTAEDT, M.D.

Indianapolis

MANY PHYSICIANS now practicing in Indiana will recall the Saturday morning heart clinic at the Indianapolis City Hospital. These sessions began when Dr. Robert Moore returned from military service at the end of World War I. At first there were attempts to halt this project. At one time space was denied Dr. Moore and his records were destroyed. It was

For many years the heart clinic was very necessary to hold the clinic in a hallway until it was restored as a unit in the out-patient department.
popular with the medical students at Indiana University even though no credit was given for attendance. Dr. "Bob" Moore and Dr. "Cy" Clark spent many Saturdays with them demonstrating heart murmurs and teaching clinical cardiology. Throughout the years many other physicians have taken part in this endeavor.

During World War II the clinic was maintained on a limited basis. When Dr. Clark returned from service Dr. Moore was too ill to take an active part in teaching.

In 1947 the training available in the General Hospital cardiac clinic was incorporated into the curriculum of Indiana University. Mr. Herman C. Krannert, a close personal friend of both Dr. Moore and Dr. Clark, became interested, and gave financial assistance by establishing a cardiology fellowship. Dr. Robert Marvel was the first Krannert Fellow. Technical assistance and equipment were obtained from funds provided by Mr. Krannert.

In 1952, following Dr. Moore's death, the clinic was dedicated to him and was named the Robert M. Moore Heart Clinic.

A program of postgraduate education has been developed under the direction of Dr. Charles Fisch. Funds for teaching cardiology became available from the United States Public Health Service through the Indiana State Board of Health. The clinic service was expanded, and

consultation on cardiac problems on the in-patient service was established. The fellowship in cardiovascular disease at the General Hospital is now accredited by the American Medical Association toward subspecialty certification.

Dr. Sheldon Pinsky is the present Krannert Fellow, and his studies have been integrated with the resident training program in the Lilly research unit in hypertension and renal disease. Also, a peripheral vascular section has been organized under the supervision of Dr. Kenneth Woolling.

Plans for the near future include the development of a cardiac catheterization team and the establishment of a pulmonary function laboratory.

A course in the interpretation of electrocardiograms is conducted for visiting and house staffs by members of the clinic. Attendance for each session in 1955 has averaged 80 physicians.

It is the earnest desire of the clinic staff to maintain the high standards of teaching established by Dr. Moore and Dr. Clark.

We wish to extend an invitation to all physicians in the State of Indiana to visit the Robert Moore Heart Clinic on Mondays or Saturdays. Visitors are also welcome for the ward walk held each Saturday at 10 a.m. A schedule of the clinic activities is listed below.

The articles in this issue of The JOURNAL have been contributed by members of the Robert Moore Clinic staff and are representative of the work that is being done.

CLINIC SCHEDULE

Adult Cardiac Clinic—1 p.m. Monday and 9 a.m. Saturday (Out-Patient Department, General Hospital)

Ward Walk—10 a.m. Saturday and 2 p.m. Wednesday (Begin at Heart Clinic)

Electrocardiography Instructional Course—7:30 p.m. Thursday (Auditorium, 4th Floor, Out-Patient Building)

Vascular Clinic—9 a.m. Tuesday (Out-Patient Department, General Hospital)

This Month's Authors . . .

Contributors of scientific papers to the annual Heart Issue of The JOURNAL are:

Ward Laramore, M.D.—Veterans Administration Hospital staff; associate visiting physician, Indianapolis General Hospital; graduate of Indiana University School of Medicine.

Robert J. Marvel, M.D.—Associate visiting physician, Indianapolis General Hospital; assistant professor in medicine, I. U. School of Medicine; in private practice; graduate, University of Nebraska College of Medicine.

P. D. Genovese, M.D.—Visiting physician, Indianapolis General Hospital; assistant professor in medicine, I. U. School of Medicine; assistant chief of medicine, VA Hospital, Indianapolis; graduate, Long Island College of Medicine.

B. L. Martz, M.D.—Associate visiting physician, Indianapolis General Hospital; assistant professor in medicine, I. U. School of Medicine; Lilly Laboratory for Clinical Research; graduate, Indiana University School of Medicine.

Charles Fisch, M.D.—Associate visiting physician, Indianapolis General Hospital; director, Robert M. Moore Heart Clinic; assistant professor in medicine, I. U.; private practice; graduate, Indiana University School of Medicine.

Digitalis

WARD LARAMORE, M.D.

Indianapolis

IN ANY PUBLICATION relating to cardiovascular disorders as befits an issue commemorative of a man vitally interested in cardiovascular disease, a discussion of digitalis and related drugs should be included. A comprehensive review of the subject would be voluminous and repetitious of standard text books and current literature on this subject. The present discussion is intended to be a survey of the digitalis drugs with emphasis on toxicity. An extensive bibliography will not be given; a few of the more important sources of information will be listed.

ACTION OF DIGITALIS

There are several actions known and many actions attributed to digitalis in its various forms. By far the most important action is a direct beneficial effect on the failing myocardium. Digitalis increases the force of systolic contraction and results in a decreased diastolic size of the heart when given to a failing heart. This results in an increased work capacity and increased cardiac efficiency with a consequent increased cardiac output. The failing heart can accomplish more work while utilizing the same volume of oxygen that was used prior to digitalization. The physiochemical basis of this increased efficiency has not been established in detail but some of the mechanism is known. It appears that digitalis is intimately related to the cellular concentration of potassium. Therapeutic doses increase the cellular concentration of potassium while toxic doses decrease the potassium content. The potassium ion is involved with the actomycin-adenosin-triphosphate complex which is responsible for muscular contraction. Better clarification of the processes await further investigation. With the improved myocardial function, slowing of the heart rate, decrease in venous pressure, and decrease in edema are logical consequences. However, some investigators have attributed these effects to direct digitalis effect on the vagus nerve, the venomotor system, and the kidney. In large doses digitalis impairs atrioventricular conduction and lengthens the refractory period of the atrial muscle. This reaction is useful in the control of or conversion of atrial flutter and fibrillation. Another well established action which has little clinical significance is the vagal stimulating effect of digitalis. This is thought by some to contribute to slowing of the heart rate, but the direct myocardial effect appears to be a more important action in accomplishing the decrease in rate.

INDICATIONS FOR ADMINISTRATION

For practical purposes, the prime indications are 1) congestive failure with or without supraventricular arrhythmias; and 2) supraventricular arrhythmias without failure. Unfortunately many non-cardiac conditions present signs and symptoms simulating heart failure; dyspnea and rales are common features of pulmonary lesions; hepatomegaly and dependent edema are present with many liver disorders. Dependent edema alone has innumerable causes as does sinus tachycardia. Inappropriate use of digitalis is not at all uncommon in these disorders. It is a rather common practice to use digitalis in circulatory shock, tachycardia, or premature systoles which occur operatively, postoperatively, and with various infections, even though not indicated in these disorders. Likewise its use preoperatively in older patients is not indicated unless there has been previous heart failure or supraventricular arrhythmia.

There are many instances of cardiac failure in which digitalis is relatively ineffective and others

in which its use is somewhat controversial. Mechanical impediments such as occur in constrictive pericarditis require surgical intervention before significant improvement can be expected. Persistence of active disease in failure as Grave's disease, myxedema, avitaminosis and severe anemia require medical treatment other than digitalis. In these instances digitalis can not be expected to be very effective but still may be helpful if used cautiously and not in excessive doses. There is some controversy about the use of digitalis in treatment of failure in active rheumatic carditis, myocardial infarction, and complete atrioventricular block. Dramatic improvement of failure does not occur and digitalization is easily carried to excess in order to accomplish compensation in these cases. Nevertheless it is logical to use digitalis cautiously in these circumstances.

While quinidine is a valuable drug in many arrhythmias, digitalis is usually the drug of choice in supraventricular tachycardia. Digitalis does not convert auricular fibrillation or flutter to sinus rhythm regularly but has accomplished this in many isolated cases. It is required for adequate control of the ventricular rate when auricular fibrillation or flutter is associated with a rapid ventricular rate and is thought by some to be useful in preventing the rapid ventricular rates in these arrhythmias when a rapid ventricular rate is not a constant feature. Digitalization may be effective in control of paroxysmal auricular tachycardia and is also a useful prophylactic drug in this arrhythmia.

SELECTION OF DIGITALIS COMPOUND

There are many forms of digitalis and its derivatives now available to the physician. Claims regarding the toxic-therapeutic ratio favoring some forms of the drug have been made. These claims have not been substantiated. At present there is no evidence of any fundamental difference in the effect of the various preparations on the heart. The dissimilarities are quantitative and are related to the rate of absorption and variability in potency and duration of action. It follows that one should become acquainted thoroughly with the use of one or two of the preparations rather than attempt to learn several. Because of the frequent inability to determine whether or not a patient treated elsewhere has been on digitalis or the inability to ascertain the amounts the patient has had previously, it appears that one should be acquainted with a short acting preparation as well as a long acting product. In instances as just cited, use of a short acting preparation will permit more rapid recovery from overdigitalization in case of misjudgment.

The long acting forms of digitalis include digitalis leaf in tincture or tablet form, digilanid, digitoxin, and gitalin. Because it is a pure chemical and completely absorbed from the gastrointestinal tract, digitoxin has become the preparation used most widely. Digitoxin can be used for rapid or for slow digitalization. Rapid digitalization should be used only in extreme cases such as severe acute congestive failure especially when associated with auricular fibrillation. An initial dose of 0.6 mg. followed by 0.2 mg. every six hours until digitalization is accomplished or approximately 1.2 mg. have been given is one method of use. Intravenous administration is rarely indicated and then only in cases with inability to swallow or retain the drug orally. Slow digitalization may be performed over a three to seven day period in doses of 0.2 mg. three times daily for three days or 0.3 mg. daily for seven days. Maintenance therapy originally was rather arbitrarily set at 0.2 mg. daily because of some early reports but resulted in intoxication in many instances. The maintenance dose must be varied to fit the individual case and may be as low as 0.05 mg. every other day or as high as 0.3 mg. daily; however, it usually is from 0.1 mg. to 0.15 mg.

The short acting forms include strophanthin, digoxin, and lanatoside C. Strophanthin is considered by some to be the drug of choice for intravenous use because of its very rapid action and short duration. Its effect starts in 1 to 3 minutes; maximum effect is present from 30 minutes to 2 hours; total duration of action less than 24 hours. Because of the rapid elimination, it is useless for maintenance therapy but is especially valuable for emergency use when previous digitalization administration is unknown. Dosage of strophanthin ranges from 0.8 to 1.0 mg. in divided doses intravenously every half hour until effect is observed. Digoxin and lanatoside C have about the same actions. Both can be used orally or intravenously. When used intravenously, action appears in about 10 minutes with maximum effect in 2 to 4 hours and total dura-

tion of effect from 4 to 6 days. Intravenously the average digitalizing dose of each is approximately 1.5 mg. This should be given in divided doses. Orally both are absorbed poorly, so that digitalization requires much larger doses and action is not as rapid as when given intravenously. When used orally the average digitalizing dose of digoxin is from 2.0 to 5.0 mg. and maintenance dose 0.5 to 0.75 mg. daily. For lanatoside C, the average digitalizing dose is from 5.0 to 10.0 mg. and the maintenance dose 1.0 mg. when given orally. Because of the relatively short duration of action of these preparations, they are most useful when the status of previous medication is questionable.

DIGITALIS INTOXICATION

Intoxication with digitalis has varied and sundry manifestations, the most common of which are gastrointestinal disturbances and abnormalities of cardiac rhythm. Less frequent and less well known are the neurological disturbances. The most frequent gastrointestinal symptom is anorexia; this is followed by nausea and vomiting; diarrhea is a later and rather infrequent manifestation. Neurological disturbances are usually not very impressive but occur in rather high incidence in older patients. Visual effects include blurred vision, color aberrations, motile spots before the eyes. Headache, dizziness, and true vertigo are occasionally present. Neuralgia-like pains have appeared in a small portion of those with digitalis intoxication. Lassitude, apathy, confusion, disorientation, delirium, stupor, aphasia, and psychosis have been noted—especially in older patients.

The cardiac manifestations deserve especial emphasis. The chief effects are varying impairment of atrioventricular conduction and increased myocardial irritability leading to disturbances of rhythm. In addition a reduction in coronary blood flow and myocardial lesions varying from focal areas of degeneration to extensive subendocardial hemorrhagic necrosis has been noted experimentally. The usual and earliest electrocardiographic changes in digitalization consist of shortening of the Q-T interval, sagging of the ST segment, and inversion of the first portion of the T wave. Unfortunately these changes provide no therapeutic index and do not signify the proximity or presence of toxicity—in fact, severe toxicity may occur in the absence of these changes. The evidence of myocardial irritability and atrioventricular conduction impairment commonly noted are multifocal premature contractions, bigeminal and trigeminal rhythms, progression of prolongation of atrioventricular conduction to third degree atrioventricular block. Less frequent evidences include auriculoventricular dissociation, auricular fibrillation, auricular tachycardia, and ventricular tachycardia. In fact every type of arrhythmia and conduction defect has been known to occur because of digitalis intoxication.

With the advent of the purified glycosides, it was felt that better control of the drug could be expected and intoxication would be lessened. Instead there has been an increase in the incidence and severity of intoxication. Some voiced the opinion that the purified drugs were more toxic in themselves and that premonitory symptoms were infrequent or absent. Observations and measured therapeutic-toxic toxicity is the same irrespective of the form administered. Factors responsible for the increased incidence of intoxication are not all known. Among the factors which appear to participate are the improper use of the drugs, an increased life span with the opportunity for development of more severe forms of failure which are more prone to intoxication and electrolyte disturbances. Intravenous use of the purified glycosides is a fairly common practice and is attended by a sizable incidence of intoxication. As stated before, the intravenous use is rarely justified. The widely publicized average digitalization and maintenance dosage of 1.2 mg. and 0.2 mg. digitoxin led to its widespread use in this dosage regardless of the patient's condition. Such a practice is usually harmless in early failure but intoxication occurs more frequently in more severe cardiac failure. Present day medical and surgical sciences have contributed to a longer life span so that severe failure has a greater opportunity to develop. The more severely decompensated and older patients are more prone to develop intoxication with digitalis. Probably the most important factor in digitalis intoxication is electrolyte disturbance. This is felt worthy of separate consideration.

In metabolic studies, a very pronounced relationship has been noted to exist between potassium and digitalis. It has been observed experimentally that toxic doses of digitalis liberate potassium from heart muscle. It has also been noted that changes in potassium concentra-

tion have a marked influence on digitalis effect. In experimental animals withdrawal of potassium increased the toxic effect of digitalis and administration of potassium decreases the toxic effects. Potassium salts have reduced or abolished ventricular extrasystoles and arrhythmias induced by digitalis in man in some cases. In congestive failure potassium is lost from the body in several ways. Anorexia, acidosis, edema, and exercise are known to induce potassium loss. Mercurial diuresis results in a marked potassium excretion. This is more marked when a restricted sodium intake reduces the amount of sodium excretion, and is enhanced by ammonium chloride administration. Diamox and the exchange resins also have marked effects on the potassium balance. The extent of the contribution to digitalis intoxication by potassium loss in these many ways is not known but appears to be worth serious consideration.

Treatment of digitalis intoxication consists primarily of discontinuing the drug if the degree of intoxication is very great or of decreasing the dosage if minor intoxication is present. Potassium salts have been given with favorable results in many of the arrhythmias. The usual amount varies from 5 to 7.5 grams of potassium chloride orally in divided doses daily. It may be given in cold fruit juice to avoid gastric irritation. If the patient is acidotic potassium citrate or acetate may be used instead of the chloride compound. Intravenous potassium chloride may be used in a solution containing 40 millequivalents of potassium chloride in 500 cc. of 5 percent glucose in water. During its administration, the patient should be followed by continuous electrocardiography and the administration halted when the T wave becomes tented or peaked. When this point is reached, oral therapy should be started. Despite its efficacy in many cases of digitalis intoxication, there is no clinical evidence favoring its long continued administration prophylactically; ordinarily the potassium ingested with the diet is sufficient. In addition, while it is stated that toxic levels of potassium do not occur in the absence of anuria, some have observed potassium intoxication in heart failure. It is mandatory that the use of potassium salts be carefully supervised in the treatment of digitalis intoxication. Pronestyl has been used in the arrhythmias associated with digitalis intoxication also. While there are some favorable reports, its use still remains in an experimental stage. Its action appears to resemble that of the potassium salts and it is theorized that its action may be produced by altering the cell membrane permeability so that the entry of the potassium ion into the cell is facilitated.

SUMMARY

A portion of the vast information on digitalis has been reviewed. Some of the knowledge concerning its basic action was noted. The prime indication for its administration was stated to be the presence of congestive heart failure of any cause; a lesser indication was the presence of a supraventricular arrhythmia. Some of the many digitalis compounds were discussed and a thorough knowledge of one long acting and one short acting form was thought to be indicated. Emphasis was placed on digitalis intoxication and it was noted that every type of arrhythmia and conduction defect has been known to occur with digitalis intoxication. The relationship of digitalis and the potassium ion was discussed and the use of potassium in arrhythmias due to digitalis intoxication was reviewed. Final information on any and all aspects of the use of digitalis remains for further clarification.

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Acute Pericarditis

ROBERT J. MARVEL, M.D.

Indianapolis

INTRODUCTION

ACUTE PERICARDITIS is said to occur usually in the presence of recognized disease elsewhere in the body, as with rheumatic fever and tuberculosis. However, in more than a few cases, the primary disease manifests itself as pericarditis with little or no evidence of the disease process elsewhere.

The problem presented by this latter group has held considerable interest for our clinic physicians and has directed our attention toward some of the differentiating features of diseases manifesting themselves primarily as a pericarditis.

The pericardium reacts to inflammation as do other serous membranes by producing a fibrinous exudate and varying types of effusion. The signs and symptoms and laboratory findings depend largely upon the degree of and type of response to this inflammation, which also frequently involves the epicardial layer of the myocardium. Several etiologic varieties of pericarditis have been noted and include rheumatic, tuberculous, acute nonspecific, uremic, pyogenic and parasitic, traumatic, those due to myocardial infarction and malignant neoplasms, and other rare forms. The reader is referred to the textbooks for detailed discussion of the various pathologic features.

The purpose of this paper is to review the clinical features of acute pericarditis and to discuss some of the problems in diagnosis and differential diagnosis.

CLINICAL FEATURES

Subjective Symptoms

General symptoms include such complaints as fever, sweating, chills, weakness, weight loss, and anxiety.

Precordial pain is considered a characteristic symptom but is often absent and is extremely variable in its distribution and intensity. Characteristically, the pain is located over the precordium and is intensified by breathing, by rotation of the trunk, by swallowing, and by lying flat. Most authorities consider the pain to be due to associated inflammation of the diaphragmatic, costal or mediastinal pleura.[1] Pericardial effusion may produce a dull oppressive pain by distention of the entire pericardial sac.

Acute cardiac compression symptoms include dyspnea, right upper quadrant pain, and swelling of the legs and abdomen. Shortness of breath is frequently the most prominent symptom and is considered to result, in part, from mechanical compression of the bronchi or lungs. With large effusions, compression of the tracheobronchial tree and esophagus may also cause a non-productive cough and hoarseness or dysphagia.

Objective Signs

Signs due to pericardial inflammation and effusion include generalized increase in cardiac dullness, pericardial friction rub, and Ewart's or Pins' sign. The presence of a pericardial rub is conclusive evidence of an acute pericarditis or an acute exacerbation of a chronic pericarditis. The rub is often very evanescent but may persist for weeks or even months. The presence of a large pericardial effusion does not preclude the presence of this rub.

Signs due to acute cardiac compression include systemic venous congestion, diminution in heart tones, fall in blood pressure, and pulsus paradoxicus. The development of these signs depends both upon the size of the effusion and the rapidity with which it forms. A paradoxical pulse is considered an almost constant manifestation of cardiac tamponade and is an accentuation of a normal mechanism.

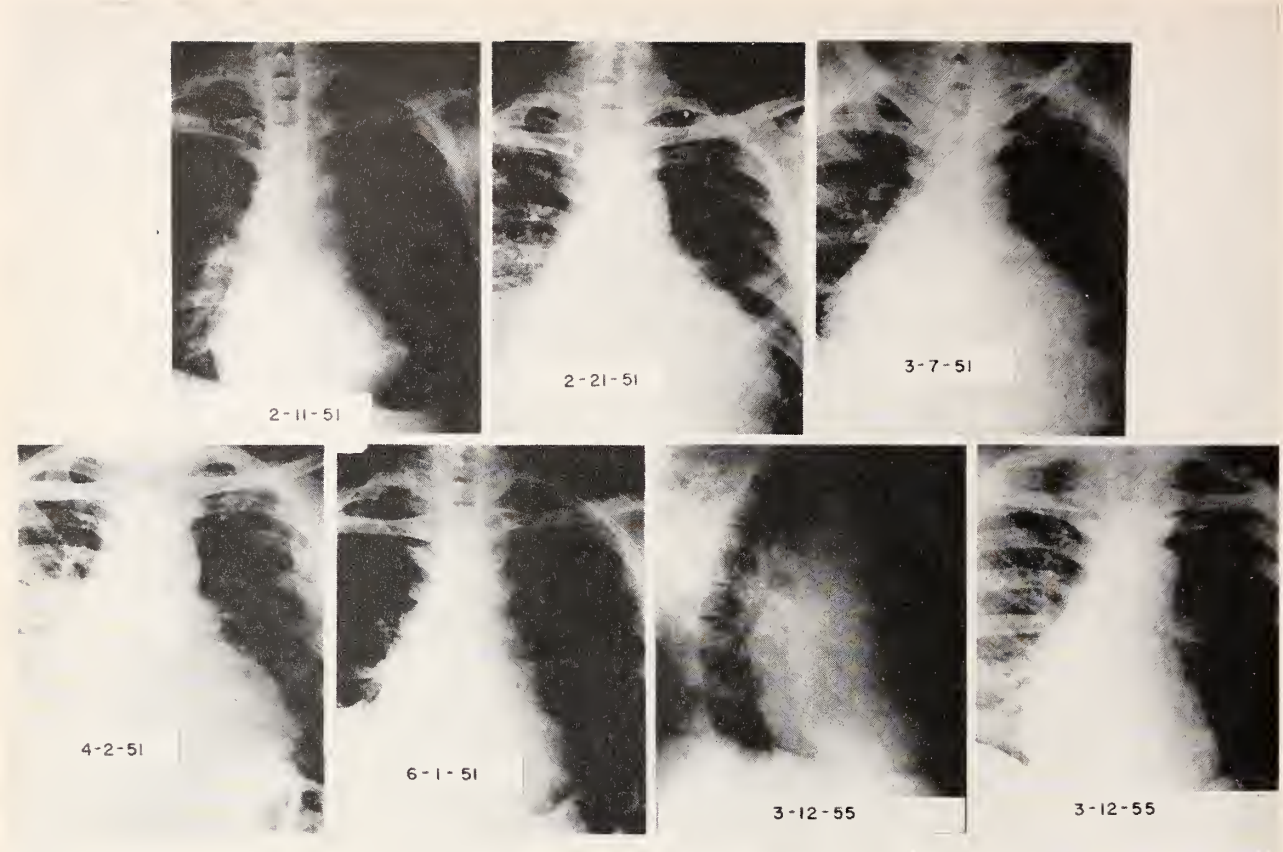


Figure 1. Serial chest X-rays revealing the changing cardiac silhouette in acute pericarditis with effusion.

The general signs of pericardial inflammation and associated disease include fever, sweating, weakness, evidence of weight loss and restlessness.

LABORATORY FEATURES

Many of the laboratory findings vary with the underlying cause of the disease, however, only those serial roentgen and electrocardiographic changes common to all types will be discussed.

Roentgenographic examination

The value of cardiac fluoroscopy and x-rays is greatly increased if serial x-rays are taken (See Figure 1). As with the physical signs, roentgen abnormalities depend on the size and distribution of the effusion. With large effusions the normal chamber contours disappear and cardiac pulsations are usually diminished or absent. Of some diagnostic value is the fact that the pulmonary vascular markings are not increased and that the aortic knob pulsations sometimes remain normal. The finding of marked impairment or absence of pulsations in the presence of normal lung fields is also helpful in differentiating pericardial effusion from cardiac enlargement due to other causes. It might be well to point out that cardiac dilatation may account for much of the enlarged cardiac silhouette in pericarditis, however, pulsations of an enlarged heart are usually not diminished unless heart failure intervenes.

Angiocardiography has been recommended to demonstrate the presence or absence of a fluid-filled pericardial shadow adjacent to the dye-filled right auricle,[2] however, this is not without pitfalls since such findings may occur in cases with marked hypertrophy of the cardiac chambers.[3]

Electrocardiographic examination

Several excellent reviews of the literature pertaining to this subject have been made.[4-6] The changes encountered in acute pericarditis are the result of subepicardial myocarditis,[7] which is manifest by alterations in the RS-T segment and T wave and by diminution in voltage. The earliest finding is that of RS-T elevation in several or all leads along with peaking and elevation of the T waves (see figure 2). It has been pointed out that, in contradistinction to myocardial infarction, T wave negativity seldom appears until the RS-T segment has returned to the baseline.[5] The amplitude of the electrocardiographic com-

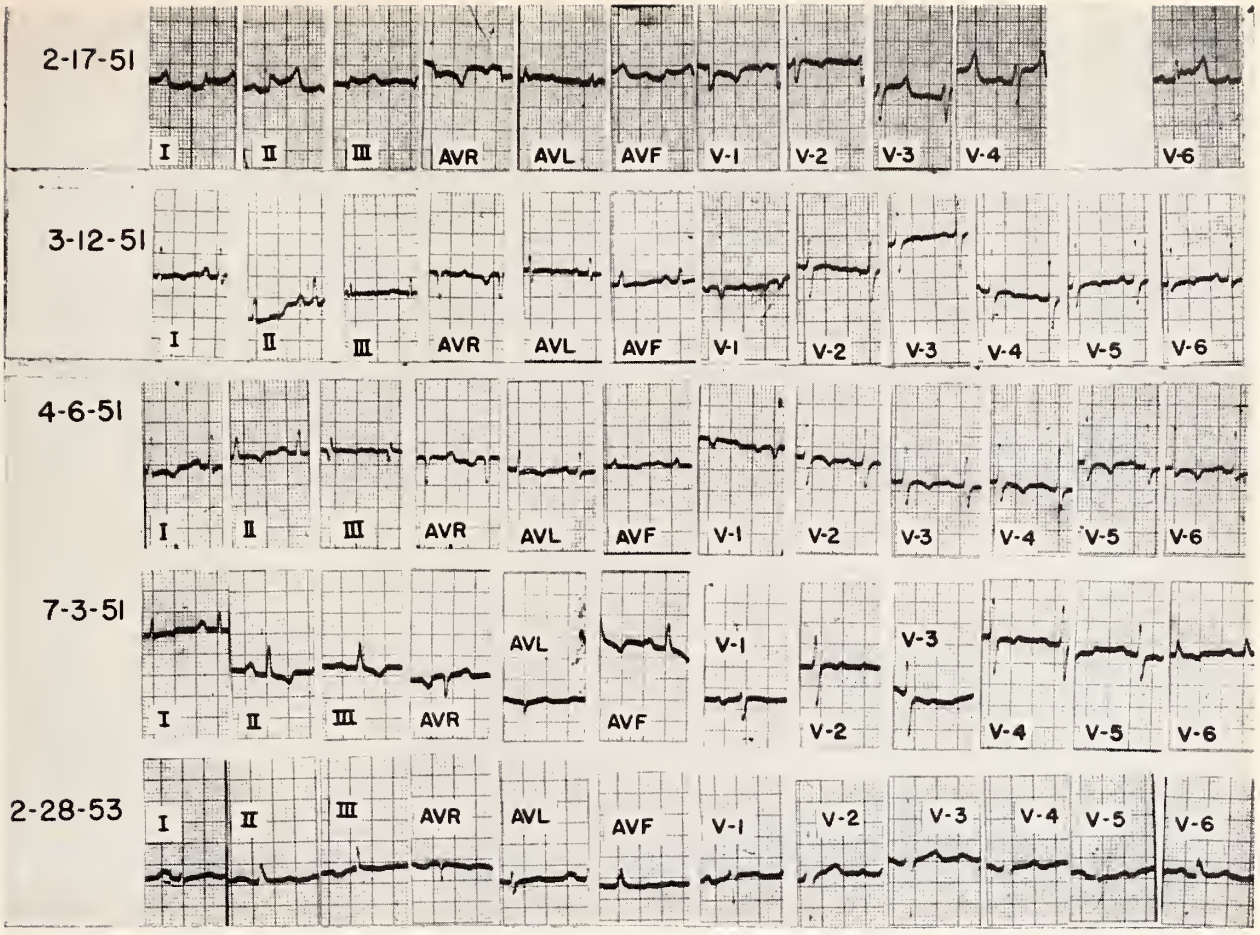


Figure 2. Serial electrocardiograms showing the evolution of acute pericarditis. Earliest changes are RS-T segment elevation, elevation and peaking of T waves, and diminution in voltage. Later changes include return of RS-T segment to the isoelectric line, increasing T wave inversion, and finally return toward a normal pattern.

plexes is frequently diminished by a pericardial effusion, but this cannot be correlated well with the size nor duration of the effusion. The above electrocardiographic changes may be entirely absent.

DIAGNOSIS

The finding of a pericardial friction rub is an absolute diagnostic finding. Along with this finding, serial x-rays of the chest and electrocardiograms, pericardiocentesis, and pericardial fluid study are helpful in establishing the etiologic diagnosis. Pericardial aspiration may serve three functions, namely, confirm the diagnosis of pericarditis, determine the etiologic type, and relieve cardiac tamponade. Stained smears and culture and malignant cell study should be made and some of the fluid should be inoculated in guinea pigs if tuberculosis is suspected or cannot be ruled out. In cases of obscure etiology, pericardial biopsy may furnish a clue as to the diagnosis.[8-10]

As mentioned before, some cases will manifest themselves as pericarditis with little or no evidence of the primary disease process. Several of these cases have been studied in our hospital and cases of the three most common etiologic types will be discussed to point out some of their clinical similarities, differentiating features, and uncommon findings.

Tuberculous Pericarditis

The clinical picture and course of tuberculous pericarditis is quite varied. The onset is ordinarily slow and insidious, fever is nearly always present and often spiking in nature, and a pericardial rub is heard in most cases. Although pain is considered to be mild by most authorities, our experience has found pain to be a prominent feature. Contrary to most opinions, we have found elevated white blood counts frequently in the acute stages of the disease. Serial electrocardiograms and chest x-rays are similar to those of other etiologic types. The peri-

cardial fluid is frequently amber or bloody and tubercle bacilli can occasionally be cultured from this fluid. The majority of cases are seen in males and in the Negro race.

Although tuberculous pericarditis is generally considered to be secondary to infection elsewhere in the body, it often appears as the only manifestation of this disease. These cases, often considered as "primary" pericardial tuberculosis, frequently develop signs of infection elsewhere in the body as in this case.

Case report: E. D., 27 year old Negro, was admitted to the hospital on July 1, 1947, complaining of chest pain and dyspnea. The patient had been in good health until one month before admission when he had the "flu," and one week prior to admission he developed substernal pain aggravated by deep inspiration and by swallowing. There was associated fever and dyspnea. The significant physical findings included a blood pressure of 112/68, distant heart tones, and negative lung fields on admission. Two days later a harsh to-and-from pericardial rub developed and persisted for two weeks. The white blood count was 18,400 with 62% polymorphonuclear leukocytes and the sedimentation rate was 36. A second strength PPD was negative. A chest x-ray on July 1, 1947 revealed marked cardiac enlargement and the heart size returned to normal by July 24, 1947. Serial electrocardiograms were entirely negative. The course in the hospital was marked by low-grade fever for two weeks, pain for four days, and dyspnea for two weeks. One year later he was hospitalized for pulmonary tuberculosis.

In this case the initial impression was that of an acute non-specific pericarditis, but the later development of pulmonary tuberculosis points to the diagnosis of tuberculous pericarditis. In this case the uncommon features were those of a normal electrocardiogram, leukocytosis, and the negative tuberculin test.

Acute Non-specific Pericarditis

Some of the important clinical features of this type of pericarditis include a history of preceding respiratory infection, occurrence in young individuals, predominance in males, and pleural effusions. The prominent symptom is chest pain and the outstanding finding is a pericardial rub. Fever is usually present. Polymorphonuclear leukocytosis and an elevated sedimentation rate are found in the majority of cases. Pericardiocentesis is rarely reported because of the infrequency of large effusions and because the cardiac enlargement is considered to be due predominantly to cardiac dilatation.[11] The electrocardiogram is usually a helpful diagnostic aid but rarely do the abnormalities persist.[12] Recurrences are not uncommon and the development of constrictive pericarditis rarely occurs.

How many of these cases actually represent tuberculous pericarditis has not been established, since it is a well-known fact that the fluid from tuberculous pericarditis may be negative on culture and guinea pig inoculation. Nevertheless, differentiation of nonspecific from tuberculous pericarditis is important from the standpoint of therapy, and pericardial aspiration is strongly recommended by some authorities before beginning antituberculous treatment.[13]

Case report: W. T., a 25 year old Negro, was admitted to the hospital on June 20, 1950, for re-evaluation of his cardiac status. The present illness dated back to 1944 when he was in military service. He was hospitalized then because of a sore throat followed by substernal pain, fever, and a pericardial rub, all of which persisted for two weeks. From 1945 to 1950 he worked without symptoms. The physical findings in 1950 included a blood pressure of 112/60, pulse rate of 84/minute, clear lung fields, and negative cardiovascular examination. In 1944 there was a strongly positive Mantoux, negative blood cultures, negative agglutinations, a normal blood count, normal serum proteins, and a sedimentation rate of 25 mm. in one hour. An x-ray of the chest in April, 1944, revealed definite cardiac enlargement with return to normal size by May, 1944. X-rays in 1950 revealed a normal cardiac silhouette but diminution in pulsations along left heart border. The electrocardiograms in 1944 and 1945 revealed inversion of all T waves and in 1950 was still abnormal with inverted T waves.

In this case the uncommon features were the normal hemogram, the persistent electrocardiographic changes, and the diminished amplitude of cardiac pulsations.

Rheumatic Pericarditis

Important features of this type of pericarditis are an age incidence which usually parallels that of acute rheumatic fever, appearance of cardiac murmurs during the course of the illness, and disturbances in conduction in serial electrocardiograms. Myocardial involvement is always present with the pericarditis of rheumatic fever.

Precordial pain and a pericardial rub are generally present.

Case report: A. B., a 37 year old white male, was admitted to the hospital on April 12, 1950, complaining of abdominal pain. An appendectomy was performed on April 12, 1950, but no appendicitis was found. Twenty-four hours later the patient developed anterior chest pain, dyspnea and fever. The physical findings of significance were a blood pressure of 112/56, pulse and heart rates of 116 per minute, clear lungs, and a loud pericardial friction rub. The white blood count was 22,500, sedimentation rate was 34 mm. per hour, x-rays revealed marked cardiac enlargement on April 22, 1950, with reduction in size by May 19, 1950. An electrocardiogram was compatible with acute pericarditis (see figure 3) and there was a prolongation of the P-R interval. The course was marked by fever of two weeks, development of arthritis in the elbows and wrists and knees on April 17, 1950, and the appearance of a soft diastolic murmur along the left sternal border after six weeks of hospitalization. He was discharged in August, 1950.

In this case the uncommon feature was the age at which a recurrence of rheumatic fever developed. The electrocardiographic findings and the development of a diastolic murmur helped establish the rheumatic etiology.

DIFFERENTIAL DIAGNOSIS

Diagnostic difficulty may occasionally arise in distinguishing acute pericarditis from valvular heart disease when the rub is confused with a murmur, from myocardial infarction when the electrocardiogram is not diagnostic or is somewhat similar to pericarditis,[14] from mediastinal tumor, from a dilated or giant left atrium, and from cardiac enlargement of undetermined origin.

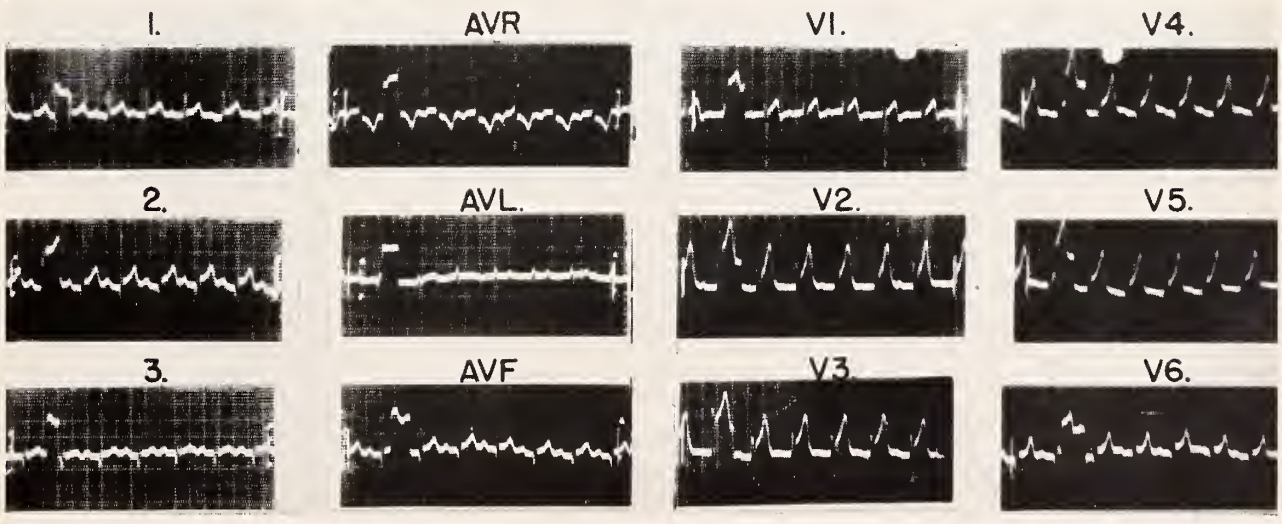
In our study of cases of cardiac hypertrophy of unknown etiology, difficulty in differentiation of this disease from that of pericardial effusion or chronic constrictive pericarditis arose because of the findings of a low pulse pressure, evidences of right heart failure, pulsus paradoxicus, distant heart tones, non-specific electrocardiographic changes, and an enlarged heart with diminished pulsations on fluoroscopy.[3] Roentgenkymographic and angiocardiographic studies did not exclude the possibility of pericardial disease in one of our cases. Graybiel and White[15] report a similar case in which surgical exploration for pericardiectomy was performed.

THERAPY

As a rule therapy is directed toward the underlying disease and not the pericarditis *per se*. However, in cases of acute cardiac tamponade, pericardiocentesis may be life-saving.

Direct drainage of the pericardium is the best method of treating suppurative pericarditis and appropriate drug or antibiotic therapy should be given. Prolonged drainage is not suitable when the pericardial fluid is sterile, and the establishment of "pleuropericardial windows" has been recommended to sustain relief of tamponade and to allow removal of accumulated fluid via the pleural cavity.[9]

Figure 3. The electrocardiographic changes of RS-T segment elevation and T wave peaking are compatible with acute pericarditis. In addition is the PR interval prolongation compatible with rheumatic myocarditis.



Some authors have advocated that, if the patient fails to respond to adequate medical management or if diagnosis remains in doubt, prompt pericardiectomy should be performed even though active disease is present. They recommend surgical resection plus chemotherapy as the procedure for treating active pericarditis in these cases.[16]

SUMMARY

The clinical and laboratory features of acute pericarditis have been reviewed and case histories of three different types of pericarditis have been presented to point out clinical similarities and differentiating features.

In our experience the most common form of acute pericarditis has been of the tuberculous type, whereas the most commonly reported in private practice has been the so-called acute nonspecific type. Despite many of the diagnostic procedures available there still remains a significant group of patients with acute pericarditis for which we find no etiology.

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General Review of Surgically Amenable Cardiac Lesions

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THE ADVANCES in cardiovascular surgery in the past 10 years have been so rapid that many of the surgical procedures have not been fully evaluated. There is, for example, doubt in some sections of the country as to the value of mitral commissurotomy except in a select few. Even the most enthusiastic proponents of mitral valve surgery[1, 2] have found it difficult at times to completely assess the results of surgery after 3 to 5 years. This article is written to review, in a general fashion, the literature concerned with the more amenable cardiac lesions.

In considering patients with cardiac lesions for surgery, the same general principles that hold for surgery in other fields can be applied. There are no dogmatic statements that can be made, however, until cardiac surgery is comparable to surgery in other fields.

The lesions that can be approached surgically may be divided into those that can be cured, those that can be improved and those which are not proven as yet. The first group includes patent ductus arteriosus and coarctation of the aorta; the second group, the tetralogy of Fallot, pulmonary stenosis with intact septum, mitral stenosis and constrictive pericarditis; and the final group, aortic insufficiency, aortic stenosis, mitral insufficiency, tricuspid stenosis, interatrial septal defects and interventricular septal defects.

In evaluating any of these patients for surgery, it is necessary to consider the mortality, the risk, the derived benefits and the course of the disease if surgery is not accomplished.

In considering patients with cardiac lesions that can be cured surgically, such as coarctation of the aorta and patent ductus arteriosus, surgical intervention is generally indicated if cardiac function is good. As a matter of fact, surgery in some may be a life-saving procedure.

PATENT DUCTUS ARTERIOSUS

The clinical diagnosis of patent ductus arteriosus is usually very simple, and can be made in approximately 90 to 95 per cent of the cases without the aid of special procedures. The features of this syndrome are reviewed in any standard text.[3] Cardiac catheterization should be used only when there is a suggestion of right ventricular hypertrophy, pulmonary hypertension or some other complication. It may have to be used at times in the absence of the typical murmur. It is well to remember that catheterization at times may fail if the oxygen saturation is high in the right ventricle as well as the pulmonary artery because of pulmonary regurgitation, or because of an associated ventricular septal defect. In an excellent review by Pinto,[4] the subject of patent ductus arteriosus was reviewed and the lesion classified into several groups; those with typical continuous murmurs, those with atypical murmurs of the pulmonic area and those without murmurs. It is interesting to note that this author believes that a diastolic rumble of the apical area in a patient with a patent ductus is prognostically significant and is a lesion that requires surgery.

Gross,[5] in an excellent review of 412 surgically treated patients, believed that all youngsters with retarded growth, congestive failure or undue fatigue, should be operated. All children and young adults, even without symptoms, should have surgery since the mortality and morbidity is so low and because the future is so doubtful.

In general, older individuals make for a more difficult operation and surgery here should be refused, unless there are signs of cardiac embarrassment. If there is a superimposed bacterial endarteritis, it is wiser to treat the infection and to delay surgery for a period of time. However, if there is no response to therapy, surgery should be performed. The optimum age at which surgery should be undertaken depends on the symptoms. If there are no symptoms, the optimum age groups are between 6 and 12 years of age. It should be emphasized that recent evidence shows that infants and young children may develop serious symptoms from patent ductus arteriosus and these should be operated earlier.

In recent years, there has been much written about patent ductus arteriosus with pulmonary hypertension. Diagnosis of this syndrome is a very difficult one.[6,7,8,9,10,11] If there is a disparity between cyanosis in the upper and lower extremities, signs of pulmonary hypertension with an atypical or absent murmur, then the diagnosis may be suspected. Electrocardiogram usually reveals right ventricle hypertrophy. Cardiac catheterization usually establishes the diagnosis. It is not uncommon for the catheter to enter directly into the descending aorta by way of the ductus, since the ductus is usually quite large. In individuals with cyanosis, surgery is usually contraindicated since the results are very poor. In patients with pulmonary hypertension, without cyanosis, recording of the pulmonary pressure at surgery may be the clue as to whether or not to ligate the ductus. If the pulmonary artery pressure falls on compression of the ductus, the ductus may be ligated. If the pressure rises, closure may be dangerous.

COARCTATION OF THE AORTA

Coarctation of the aorta is another congenital anomaly that can usually be detected by ordinary physical examination. The physical findings, X-ray findings and electrocardiograph findings have all been reviewed many times and need no comment.[12] Cardiac enlargement is unusual in this anomaly and should suggest some other complicating lesion, perhaps aortic valvular disease or congestive failure. Angiocardiography is only rarely indicated as part of the study. At times the differentiation from hypoplasia of the aorta, when other signs of aortic constriction of the aorta are present, can be made by angiocardiography.

Surgery for this anomaly has been available since 1944. Gross[5] believes that almost all patients with coarctation of the aorta should have surgery. The mortality figures in this type of surgery are reasonably low. In a small percentage, surgery may be postponed if the blood pressure is near normal range. However, it is imperative that these individuals be followed closely for signs of increasing hypertension. At the cardiac clinic of our hospital we have seen several young females with borderline hypertension with very little disability and no visible evidence of collateral circulation. In all of these, surgery was deferred.

Severe aortic insufficiency, congestive failure and rheumatic mitral disease of a severe degree, all increase the surgical risk and represent an almost absolute contraindication to surgery. Hufnagel[13] has inserted a plastic valve in the descending aorta in one of our patients with coarctation and aortic insufficiency. Prior to surgery, the patient was incapacitated by severe congestive failure. Since surgery, he has been able to work in a less strenuous occupation without significant symptoms. Recently the patient has developed visual disturbances as a result of repeated retinal hemorrhages.

Infants with coarctation may be seriously embarrassed by this anomaly. If the congestive failure can be controlled by medical means, this should be the treatment of choice. Ellen and Goldberg[14] handled 23 infants with coarctation medically. In 13 cases of uncomplicated coarctation, the response to heart failure therapy was excellent and after 1 year, medical treatment was no longer necessary. In the infants with other complicating congenital defects there were 7 deaths, and the 3 survivors responded to treatment less promptly and required treatment for a longer period of time. These authors concluded that medical therapy is the treatment of choice in infants and believe that, if possible, surgery should be postponed until the aorta more nearly reaches adult size. After 35 or 40 years of age, surgery is a much more difficult problem and should be considered only after careful evaluation of the patient's effort tolerance. Even with the excellent results that have been obtained with aortic grafts, surgery may fail because of a long

coarctation, a very rigid aorta or aneurysmal dilatation of the aorta beyond the constriction.

PULMONARY STENOSIS WITH INTACT SEPTUM

Surgical treatment for pulmonary stenosis with intact septum has been established. In England, pulmonary valvotomy by the ventricular approach is the popular operation. The results are usually good and the procedure is not unduly dangerous. In uncomplicated pulmonary stenosis, the narrowing may occur at the valve or in the infundibulum. At times both lesions are found. In the valvular type, the stenosis is one in which the cusps are fused and there is a dome-like projection with a small lumen. The infundibular type consists of a long, narrow myocardial stenosis. The indications for surgery are not universally uniform but almost everyone agrees that many patients do not need surgical intervention. If symptoms are present, the heart is enlarged, or there is a high, right ventricular pressure, then surgery should be considered seriously. In a review by Campbell and Brock,[15] 58 cases were summarized. Twenty-five of these were cyanotic and another 7 became cyanosed after exercise. Fifty patients have been followed for 2 years and of these, only 4 showed no improvement. There were 8 deaths, 5 of which occurred in the first 6 patients who were operated upon. Cyanosis usually indicated an increased risk and it was felt that if considerable cyanosis was present, the optimum time for surgery had passed. Postoperative cardiac catheterization studies revealed that the right ventricular pressure had fallen to less than half the former figure and in many, the pressure gradient had diminished remarkably. Hosier[16] reported 89 cases with essentially similar results.

Swan[17] and others used a trans-arterial valvular approach under direct vision using hypothermia.

TETRALOGY OF FALLOT

As stressed by Taussig,[18] the tetralogy may present itself in various ways. The degree of cyanosis varies. Cyanosis may not appear until 6 months of age and may not manifest itself until the infant starts to walk. In general, the more intense the cyanosis the greater the degree of incapacity. The essential physical findings are usually a basal systolic murmur and thrill with a weak or absent second heart sound at the base. The heart is slightly enlarged. Electrocardiogram usually reveals right ventricle hypertrophy and the typical X-ray reveals a concavity to the left of the sternum with diminshed pulmonary hilar markings. It is well to remember, however, that cyanotic children may have no murmur and some with a loud murmur may not display cyanosis until after exercise.

In a follow-up review by Taussig[19] of 1,000 patients operated on for pulmonary stenosis or atresia, there were 857 with the tetralogy of Fallot. The purpose of surgery, as is well known, is to increase the pulmonary blood flow by way of an artificial anastomosis between the systemic and lesser circulation. The results were divided into good, fair, unimproved and died. In those with the tetralogy of Fallot the results were superior to those with other malformations with basic decrease in pulmonary blood flow. There were 730 with the tetralogy that survived and of these, 674 had good results. In the latter group, there was an increase in oxygen saturation with the red blood count, hemoglobin and hematocrit returning to near normal. In reviewing the mortality figures, it was interesting to note that the mortality rate was lowest in the group with the good results and highest in those who postoperatively manifested no improvement. In the individuals with pulmonic stenosis and an intact septum (five), cardiac failure developed and the authors agreed that a pulmonary valvotomy was preferable in these individuals. In a certain number who failed to maintain improvement, a second operation may be indicated. In this particular series, there were 40 second operations. Incidentally, the incidence of subacute bacterial endocarditis remained very low (less than 1%).

In general then, many children with cyanosis and polycythemia, especially those with the tetralogy, can be helped by operation. It is felt by Taussig that the optimum time for the operation is usually between 8 and 14 years of age. The Blalock anastomosis or the Pott's procedure may be used.

VASCULAR RING

In the majority of cases, the vascular ring appears as an isolated anomaly. The outstanding symptoms are stridor and dysphagia. At times, bouts of dyspnea with cyanosis develop. These infants are subject to frequent superimposed respiratory infections. X-ray and fluoroscopic

studies usually establish the diagnosis. Lipiodol should be used in children for delineation of the esophagus. The difficulty caused by a ring can be ameliorated by surgical intervention. At times an operation may be urgently indicated. If a vascular ring is found on routine examination and remains asymptomatic, an operation should not be performed.

Closure of septal defects have been performed in many sections of the country, but the results have not been clearly defined. There have been several different methods applied to close defects with varying results. However, because mortality figures are still high and the results questionable, surgery at this time seems to be justified only in a few patients with severe or intractable heart failure.

SUMMARY

The congenital lesions that are amenable to surgery have been briefly reviewed. The results of surgery in acquired lesions, principally mitral stenosis, will be reviewed in the future.

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Dietary and Drug Therapy of Edema

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OBVIOUSLY IN A DISCUSSION of the therapy of congestive heart failure, a consideration of diuretic agents cannot be separated from the other aspects of management. It is a common observation that activity restriction and digitalization frequently result in edema control without the need for unpleasant dietary restriction of sodium and therapeutic agents having a specific diuretic action.

If the above measures do not suffice in edema control, the physician must decide how best to combat the excessive sodium and water retention associated with heart failure. It would seem that the most rational approach is to restrict the ingestion of sodium, an essential building block of edema fluid, to a level which equals the individual's capacity for excretion. Dietary limitation usually results in an approximately equal decrease in sodium and chloride intake, thus is not productive of any electrolyte imbalance. With the greater availability of low sodium foods, the task of dietary restriction of sodium is becoming simpler. Since bread and butter provide such a major portion of the usual intake of sodium (one slice of regular bread—200 mg. of sodium; one 10 gram pat of butter—100 mg.), substitution of salt-free bread and butter is frequently the only major alteration that need be made in the patient's diet habits. When salt-free bread is not available, palatable breads can be prepared by substituting 1½ teaspoons of sodium-free baking powder (see Table 1) for each teaspoon of regular baking powder. Use of special bread and butter, coupled with avoidance of obviously salty foods and processed meats, reduces the usual sodium intake of 3-6 grams to a level of approximately 1 gram per day. Many patients with congestive heart failure can be maintained free of edema when this degree of dietary restriction of sodium is added to their general therapy. In patients with more severe retention of sodium and water, to maintain the edema-free state without specific diuretic agents may require restriction of dietary sodium to 500 mg. per day or less. With proper dietary instruction and a willingness to co-operate, acceptable diets can be prepared at this level as illustrated in Table 2.[1]

Table 1

FORMULA FOR SODIUM-FREE BAKING POWDER

Potassium bicarbonate	**39.8 gm.**
Cornstarch	**28.0 gm.**
Tartaric acid	**7.5 gm.**
Potassium bitartrate	**56.1 gm.**

Frequently circumstances and clinical judgment do not permit restriction of sodium to the level that is necessary to control edema; thus supplementary diuretic agents are required.

Mercurial preparations for parenteral administration are certainly the most potent diuretic agents available. All commercial preparations are approximately equal in their mercurial content, absorbability, and thus diuretic efficacy. Although it was necessary to administer the earlier preparations intravenously because of their irritating properties, all presently available mercurials are well tolerated intramuscularly; several can be given subcutaneously with minimal local discomfort. There appears to be little reason for accepting the greater risk of intravenous administration (probably related to cardiac arrhythmias) and rarely, if ever, is their diuretic potency greater following intravenous rather than intramuscular administration.

Controversy still exists regarding the site of action of mercurial diuretics. Recent studies have indicated they probably act by inhibition of chloride reabsorption in the *proximal* renal

Tablie 2

DIET A[1]—500 MG. SODIUM[2] DIET

Morning		Noon		Evening	
Citrus fruit juice (small glass)	trace[3]	2½ ounces meat, fish or poultry[5]	52 mg.	2½ ounces meat, fish or poultry	52 mg.
1 egg	70 mg.	½ cup leafy, green or yellow vegetable[6]	9 mg.	1 medium potato[8] (150 gm.)	4 mg.
½ cup cereal[4]	trace	½ cup fruit[7]	2.5 mg.	½ cup vegetable[9]	4 mg.
1 cup milk	122 mg.	1 slice salt-free bread	9 mg.	1 slice salt-free bread	9 mg.
1 slice salt-free bread	9 mg.	1 pat salt-free butter	trace	1 pat salt-free butter	trace
1 pat (10 gm.) salt-free butter	trace	1 cup milk	122 mg.	½ cup fruit	2.5 mg.
Coffee	trace			Seasoning[10]	

[1] The above list provides approximately 1600 calories with a satisfactory distribution of protein, fat, carbohydrate, and the recommended dietary allowances of all minerals and vitamins. Calories can be adjusted to patient's needs by varying the amount of sugar, jelly, unsalted fat, cereals, salt-free bread, potatoes, etc., allowed.

[2] Values for sodium are those naturally occurring in food without addition during processing or cooking.

[3] "Trace" indicates 2 mg. or less sodium per serving.

[4] Includes all cooked cereals (not quick cooking), puffed wheat, shredded wheat, puffed rice.

[5] No "processed" meats.

[6] Fresh or frozen, unless labeled "Dietetic"; asparagus, green lima beans (not frozen), peas (not frozen), broccoli, brussels sprouts, lettuce, okra, peppers, pumpkin, squash, turnip greens (carrots, kale, beet greens, chard, and spinach not allowed).

[7] Fresh, canned, or frozen.

[8] Sweet potato, macaroni, rice, or spaghetti may be substituted.

[9] Allowed are cauliflower, corn, cucumbers, eggplant, onions, parsnips, radishes, rutabagas, tomatoes, cabbage (beets, celery and white turnips not allowed).

[10] Avoid salted fat, garlic salt, celery salt, onion salt, catsup, prepared mustard, steak sauce. Most herbs can be used.

Diet B—Diet A can be modified to approximately 1.5 gm. sodium per day by allowing 3 slices of regular bread (200 mg. sodium per slice) plus 3 pats regular butter (approximately 100 mg. sodium per 10 gm. pat) per day.

Diet C—Diet B can be modified to approximately 3 gm. sodium per day by having patient measure ¾ tsp. salt (equal to approximately 1.5 gm. sodium) into a salt shaker for daily use as seasoning.

tubules.[2] Almost invariably, the increased water excretion following administration of a mercurial diuretic is associated with a greater loss of chloride than sodium in relation to the plasma ratio of these two ions. Mercurial diuretics frequently result in a significant increase in potassium as well as sodium excretion. Thus administration of mercurial diuretics often results in a decrease in plasma chloride and increase in carbon dioxide content, contributed to both by the greater loss of chloride than sodium and the decrease in intracellular potassium with its associated hypochloremic alkalosis. It is important then that patients requiring frequent injections of a mercurial diuretic be given a liberal supply of chloride ion (usually administered as 3-12 grams of ammonium chloride per day three or four days per week) and potassium. The latter can be furnished as orange juice, which supplies approximately the equivalent of 1 gram of potassium chloride per 200 cc.; potassium chloride, 1 gram two or three times daily; or Potassium Triplex, 1 teaspoon two or three times daily. Attention to an adequate potassium intake decreases the risk of digitalis intoxication.

The common denominator in most instances of mercurial diuretic unresponsiveness is a diminution in the amount of chloride ion reaching the site of action of the mercurial diuretic—probably the proximal tubules. This can be the result of a marked diminution in glomerular filtration associated with glomerular disease, a markedly inadequate cardiac output, or from a low concentration of chloride in plasma and thus glomerular filtrate. Maintaining a normal or slightly elevated plasma concentration of chloride is largely responsible for the enhancement of mercurial diuretic activity associated with ammonium chloride administration.

Other therapeutic maneuvers which may en-

hance the diuretic activity of mercurial preparations are enforcement of decreased activity for several hours following injection, intravenous administration of a theophylline preparation 30-60 minutes after the injection of the mercurial diuretic (see Table 3), the deliberate production of hyperchloremia by the simultaneous administration of 12 grams of ammonium chloride per day and 250 mg. of Diamox three times daily.

Table 3 shows representative electrolyte excretion patterns in a patient with rather resistant edema observed during a prolonged period of hospitalization. The diuretic agents available for oral administration are considerably less potent than injectable mercury. In fact, rarely does one observe a diuresis as great as that produced by ¼ cc. of an intramuscular or subcutaneous mercurial diuretic injection.

It is seen in Table 3 that 250 mg. of Diamox resulted in an increase in urinary excretion of bicarbonate, sodium, and, to a lesser extent, potassium. With this agent, urine loss of sodium is usually less on the second day of administration than on the first with an even greater decrease by day 3. In most patients, it is advisable to administer this carbonic anhydrase inhibitor for two consecutive days once or twice per week. The oral administration of mercury in a dosage of 60 mg. usually results in a moderate increase in urine chloride and sodium. Aminometramide, in a dosage of 200 mg. three times a day, provides another means of producing a moderate

Table 3

EXAMPLES OF URINE ELECTROLYTE PATTERNS FOLLOWING VARIOUS DIURETIC AGENTS

(R. J. No. 284199)

Hosp. Day	Diuretic Agent	24 hour urine mEq.					
		Wt.	Vol.	Sod.	Potas.	Chlor.	Bicarb.
10	None	153	1160	24	49	68	
11	None	152	1325	19	45	56	4.2
12	250 mg. Diamox	152	2295	90	57	44	71.0
13	250 mg. Diamox	150	1590	48	51	26	33.2
14	250 mg. Diamox	149	1590	45	47	25	29.0
15	2 cc. Mercury	146	3160	285	54	300	
16	2 cc. Mercury plus Aminophylline IV	144	3340	340	44	351	
17	None	136	1470	19	36	14	
48	None	135	2100	17	55	45	
49	None	136	1480	26	49	54	
50	250 mg. Diamox	136	1900	82	60	63	
51	250 mg. Diamox	135	2360	73	73	66	
86	Oral Mercurial Diuretic 60 mg. Hg.	134	2700	43	14	64	
129	None	140	1900	20	40	27	
130	None	140	1480	14	17	10	
131	250 mg. Aminometramide* T.I.D.	139	2860	57	41	73	
132	250 mg. Aminometramide T.I.D.	137	2740	69	47	103	
133	250 mg. Aminometramide T.I.D.	136	2760	52	37	73	
134	250 mg. Aminometramide T.I.D.	135	2900	73	37	88	
149	None	136	1440	23	48	34	
150	None	137	1300	26	35	23	
151	Mercury suppository 165 mg. Hg.	137	1760	21	39	42	
152	2 suppositories 330 mg. Hg.	137	1480	28	44	47	
153	Mercury—1 cc. Subq.—40 mg. Hg.	138	1820	44	39	78	

Sodium intake throughout study 500 mg. (20 mEq.)

*** Mictine—Searle**

increase in urinary excretion of sodium and chloride.

The above agents used singly or in combination frequently allow some liberalization of dietary intake of sodium and elimination or infrequent administration of mercurial diuretics.

Still other means are available for enhancing body loss of sodium. Carbo-Resin* administered in a dosage of 16 grams three times daily usually accomplishes with a 1.5 gram sodium diet the same degree of edema control which by diet alone would require restriction to 500 mg. per day. In patients receiving 3 grams of dietary sodium per day, administration of the same dosage of sodium removing resin is approximately equal to dietary restriction to 1.5 grams per day. Frequently, supplementary potassium administered before meals, the resin after meals, is necessary to maintain optimal body stores of potassium. Administration of sodium removing resins increases plasma chloride concentration slightly and thus enhances the activity of mercurial diuretics.

Occasionally, marked edema of the lower extremities, especially in patients maintained in the sitting position, poses a problem in edema control. If there appears little risk of precipitating pulmonary edema, it is frequently helpful to assist those local factors acting against an increase of interstitial fluid by applying elastic wrappings to the lower extremities and/or maintaining the lower extremities in an elevated position during the several hours following the administration of a diuretic agent.

Occasionally, removal of subcutaneous fluid by Southey's tubes or the modification recently suggested by Wild[3] produces dramatic weight loss. With this therapeutic procedure, there is little or no risk of electrolyte imbalance since obviously water, sodium, chloride, and other electrolytes are removed in the ratios existing in edema fluid.

Refractory edema is not infrequently associated with hyponatremia, the result not of sodium deficiency *per se* but the retention of relatively more water than sodium. Total body stores of sodium are high but concentration, at least in the extracellular fluid, low. In these patients, co-existing renal disease is frequently a complicating factor. If the hyponatremia has developed slowly and has not been associated with acute sodium losses, there rarely is a satisfactory response to hypertonic saline infusion. If such correction is attempted, it must be done in conjunction with restriction of water intake, both orally and parenterally. Usually the patient retains the administered sodium and soon dilutes back to the original hyponatremic level. It has been emphasized that this hyponatremic state usually carries with it a very grave prognosis. Occasionally, reversal is accomplished by administration of rather large amounts of potassium in association with increasing doses of digitalis. The maneuvers for enhancing mercurial diuretic efficacy referred to earlier are also occasionally of assistance.

* 'Carbo-Resin' (Carbacrylamine Resins, Lilly).

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Diagnosis and Management of Rapid Cardiac Arrhythmias

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CARDIAC ARRHYTHMIAS represent a rather common and fascinating aspect of clinical medicine. Rare indeed is the individual who has not experienced at one time or another the sudden "sinking sensation in the chest or pit of the stomach," "grab at the throat," momentary "stoppage of the heart" or a sharp "heart pain," symptoms so characteristic of premature systoles. Fortunately the vast majority of premature systoles occur in normal hearts and require no treatment.

There is, however, a group of cardiac arrhythmias which by the very nature of a rapid heart rate may endanger the patient's life. It is this small group of arrhythmias which not only require considerable skill in "bedside" diagnosis but also tax the therapeutic ingenuity of the attending physician. Included in this group are paroxysmal auricular and nodal tachycardia, auricular fibrillation, auricular flutter and ventricular tachycardia.

A diagnosis of cardiac arrhythmia is never complete without electrocardiographic confirmation. On occasions, however, it is not feasible to obtain an electrocardiogram and the physician must rely on history and physical findings to make the diagnosis. History should include a search for symptoms of heart disease and any evidence of digitalis therapy. The latter drug has been implicated at one time or another as a cause of every known form of arrhythmia. Careful physical examination coupled with the history may allow the physician to make a reasonably accurate diagnosis of the arrhythmia. One must realize that whenever a diagnosis is made without electrocardiographic confirmation, the statistical significance of certain signs in the differential diagnosis must be known to the physician and he must rely heavily on this knowledge. Although there is a definite overlapping of the clinical features, some findings are more indicative of one type of arrhythmia than another. For example, a rate of 220 or over which is perfectly regular is statistically indicative of paroxysmal auricular or nodal tachycardia, although rarely an auricular flutter with a 1:1 response, and even less commonly, ventricular tachycardia may attain or exceed this rate.

In general, patients tolerate some tachycardias for hours and sometimes days. As a rule deterioration of the patient's status parallels the rate and severity of the underlying heart disease. The seriousness of the situation and need for vigorous therapeutic measures are signaled by appearance of one or more of the following syndromes:

(1) Inadequate cardiac output with shock and anuria.

(2) Myocardial ischemia with anginal pain which may progress to frank infarction.

(3) Congestive heart failure.

Having made some general comments pertaining to all arrhythmias we will now discuss briefly each form separately.

PAROXYSMAL AURICULAR AND NODAL TACHYCARDIA

Paroxysmal auricular and nodal tachycardia are most common of the group under discussion. It would serve no useful purpose to discuss these two varieties of supraventricular tachycardias separately, for very often a differential diagnosis is impossible and the treatment is the same in both. Paroxysmal auricular tachycardia is suggested by a sudden onset of a rapid heart

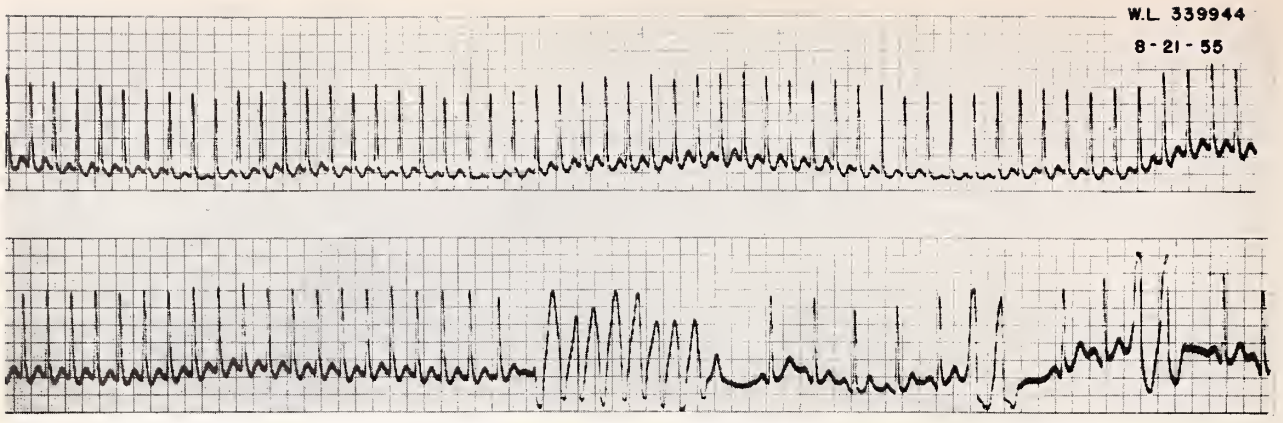


FIG. 1. This tracing shows an auricular tachycardiaand conversion to sinus rhythm by carotid pressure. The unusual feature here is a short run of ventricular tachycardia preceding appearance of sinus rhythm.

rate, with the latter varying from 140 to 240 per minute with an average rate of over 200 per minute. The rhythm of an established tachycardia is perfectly regular and vagal stimulation may not affect the rate or may slow it slightly. Since these arrhythmias are often superimposed on a normal heart, the patient may tolerate the rate surprisingly well for hours and days. The episode may cease abruptly. The disturbance usually terminates with a short period of asystole,

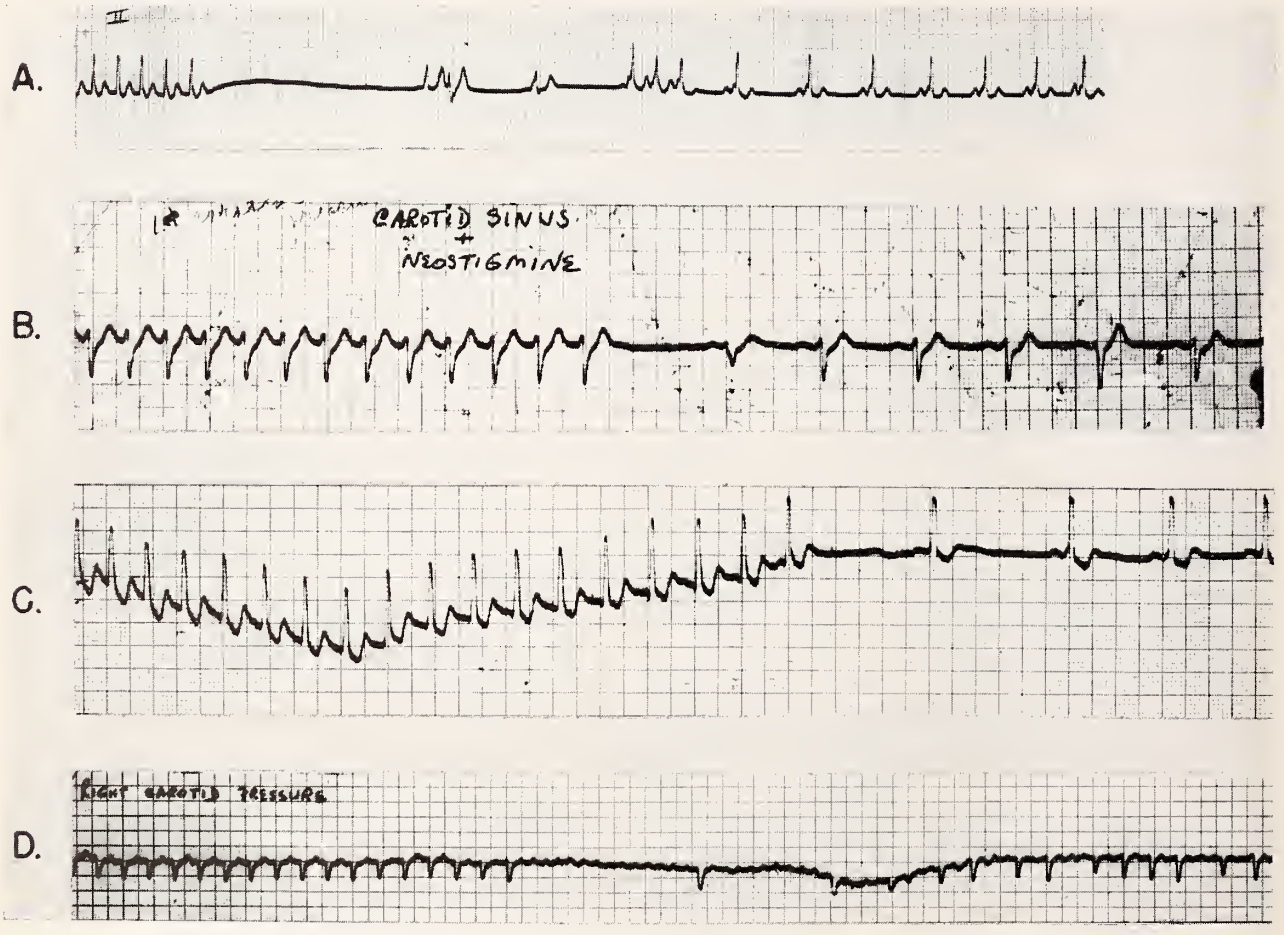


FIG. 2. A. This strip shows an auricular tachycardia in a patient with a pre-existing Wolff-Parkinson-White syndrome and its termination with carotid sinus pressure.
B. In this case carotid sinus pressure after administration of prostigmine resulted in reversion to sinus mechanism.
C. Auricular tachycardia in this instance was terminated by eyeball pressure.
D. This tracing shows a regular ventricular rate of about 180. Auricular tachycardia was suspected. However, carotid sinus pressure reveals the underlying mechanism to be auricular flutter.

although auricular fibrillation and ventricular tachycardia have been described (Fig. 1).

Treatment of this condition is difficult to evaluate because the tachycardia may stop spontaneously at any time. Initially vagal stimulation should be tried (Fig. 2). This may be accomplished by Valsalva experiment, eyeball pressure, pulling on the tongue or gagging. In case these maneuvers fail, which is often the case, carotid sinus pressure should be tried. Each carotid artery should be pressed separately. It is rarely justified to massage both carotids simultaneously. If pressure is applied properly a satisfactory result may be expected in about 50 per cent of the patients. Should all the above measures fail, we administer .5 to 1.0 mg. of prostigmine subcutaneously and repeat the maneuvers in about 20 to 30 minutes. Prostigmine by inhibiting cholinesterase potentiates the action of acetylcholine, the mediator of vagal impulse. Next step in attempting to stop the arrhythmia is to administer digitalis. Since the vagal effect of digitalis alone may give the desired result full digitalizing doses are rarely necessary. As a rule we administer .6 to .8 mg. of digitoxin. The digitalis in combination with vagal stimulation nearly always terminates the arrhythmia. Occasionally one is forced to use larger doses of digitoxin. We choose to say nothing about pronestyl, quinidine or intravenous digitalis preparations for we have yet to see an individual with paroxysmal auricular tachycardia not due to digitalis who did not respond to one or another of the above measures. (Fig. 3).

AURICULAR FLUTTER

Auricular flutter is practically always a manifestation of severe form of heart disease and consequently the patient may find himself in serious difficulty with rates well below 200 per minute. Auricular flutter should be suspected in any patient with heart disease who has a regular rate varying from 140 to 180 per minute. Very rarely does the rate exceed 200; however, in the exceptional case of a 1:1 ventricular response the rate may be over 200 (Fig. 4). On occasions the rate may be irregular because of changing degree of auriculoventricular block. In such instances, however, in contradistinction to fibrillation, many of the beats will be spaced evenly. The diagnosis is almost certain if carotid pressure, by increasing the degree of block, suddenly reduces the rate by one third or one half and the cessation of carotid pressure allows the rate to return to control levels (Fig. 4). Admittedly a differential diagnosis of auricular tachycardia and rapid (200 or over) auricular flutter, especially if the latter fails to respond to vagal stimulation, may be impossible on basis of clinical finding. The same may be true even after an electrocardiogram is obtained. Fortunately the treatment of choice of either arrhythmia is digitalis.

The treatment of emergency situations result-

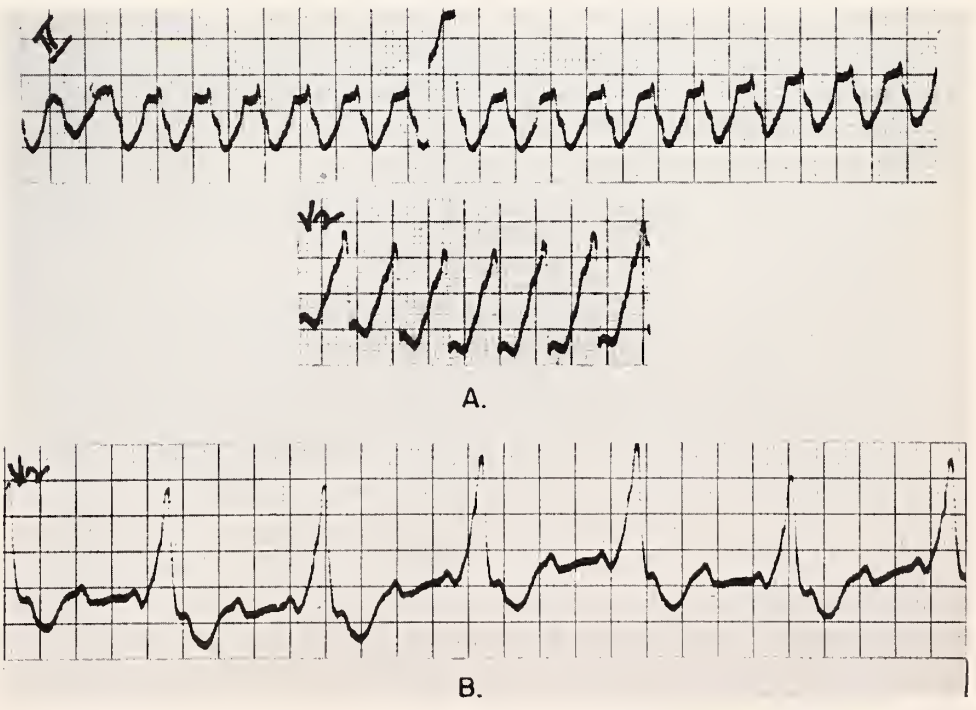


FIG. 3. Part A Leads II and V_2 disclosed a rate of 200. The QRS complexes are aberrant and ventricular tachycardia was suspected. Because of suspicion of digitalis intoxication the patient was given quinidine. In part B the mechanism becomes clear and reveals an auricular tachycardia with a 3:1 block and bundle branch block.

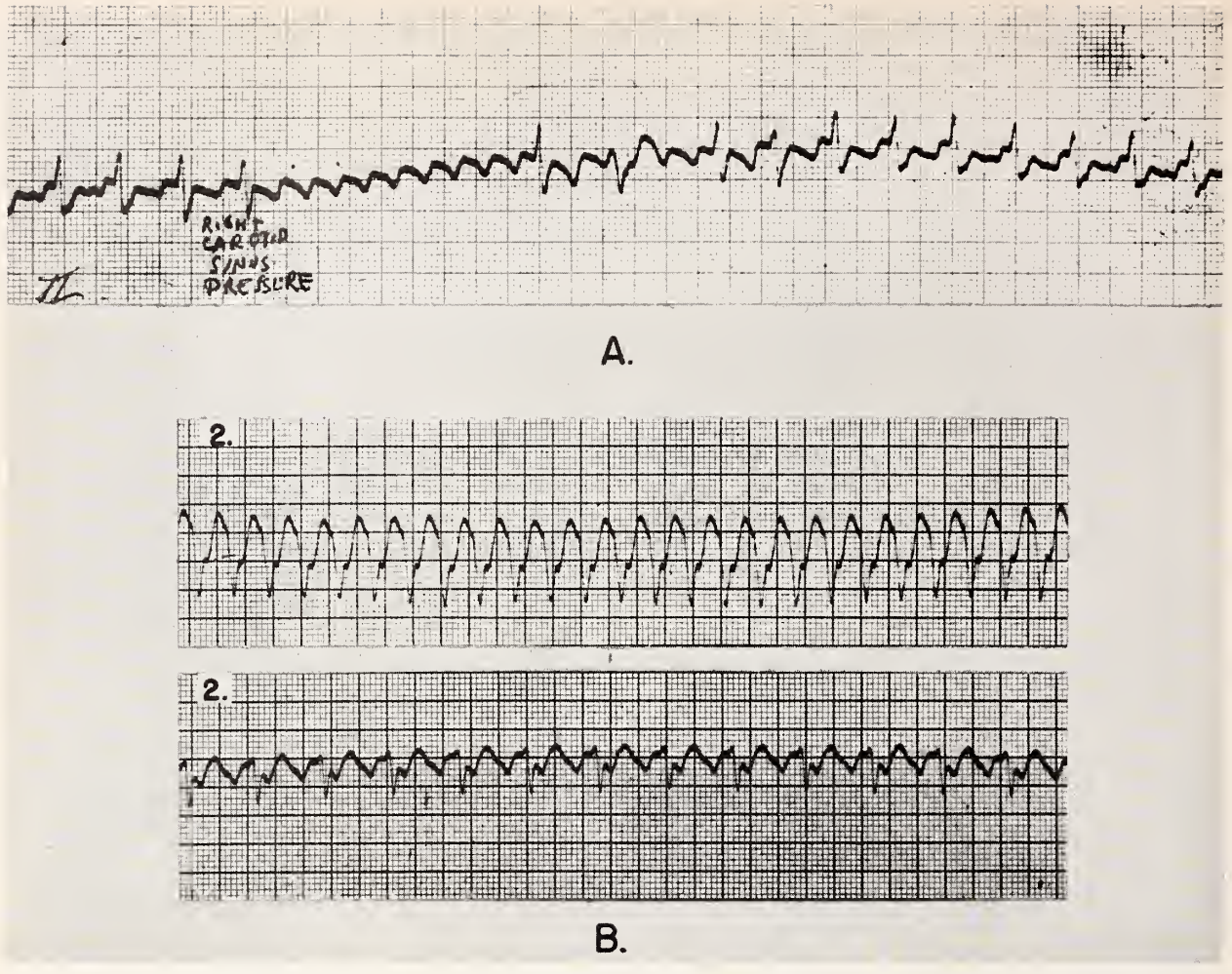


FIG. 4. A. Auricular flutter with a 2:1 ventricular response. Carotid sinus pressure increased the degree of block and discontinuation of vagal stimulation allowed the resumption of the original rate.
B. This is an unusual tracing of an auricular flutter with a 1:1 response. Upper tracing shows a regular rate of 240 per minute. The aberrant conduction suggests ventricular tachycardia. However, administration of prostigmine by increasing the block revealed that the true mechanism was one of auricular flutter.

ing from tachycardia is directed toward reduction of the ventricular rate. In auricular flutter this can be accomplished by the use of a digitalizing dose of digitalis. The drug accomplishes its objective by the direct effect on conduction tissue. With an increase in degree of auriculoventricular block the ventricular rate is reduced. Later, perhaps, the flutter may convert to fibrillation. Quite frequently cessation of digitalis therapy will result in resumption of sinus rhythm. The actual conversion of flutter to sinus mechanism is rarely an emergency procedure and thus any reference to quinidine and pronestyl is being purposely omitted.

AURICULAR FIBRILLATION

Auricular fibrillation must be considered a manifestation of organic heart disease. Cases in which there is no evidence of heart disease are extremely rare. In this condition, as in auricular flutter, the seriousness of the associated heart disease may predispose to severe cardiovascular complications even with rates not much above 150 per minute.

This condition is easily diagnosed by the presence of irregular, rapid heart rate with a pulse deficit and varying intensity of the first heart sound. Only occasionally will an extremely rapid auricular fibrillation give an illusion of regularity.

The treatment of choice of auricular fibrillation is digitalis. Slowing of the ventricular rate can be attained in a great majority of patients. If one fails to slow the ventricles the presence of "high output" failures such as thyrotoxicosis, anemia and rarely beri-beri should be suspected. Again, as in auricular flutter the conversion of the fibrillation to sinus rhythm is never an emergency and will not be discussed here.

VENTRICULAR TACHYCARDIA

Ventricular tachycardia is a relatively rare form of cardiac arrhythmia, but its appearance represents a true medical emergency which is in every way comparable to diabetic coma or massive and persisting gastro-intestinal hemorrhage.

This condition should be suspected whenever severe heart disease, especially recent myocardial infarction, is complicated by sudden appearance of a ventricular rate between 150 and 180 per minute. The rate is regular or slightly irregular, auscultation reveals a changing intensity of the first heart sound, and vagal stimulation has no effect on the rate. The tachycardia is quite often paralleled by deterioration of the patient's cardiovascular status.

The problem of treatment is complicated by the extreme difficulties encountered in accurate diagnosis of ventricular tachycardia (Fig. 5). The electrocardiographic pattern of many of the supraventricular tachycardias with aberrant conduction or pre-existing intraventricular conduction defect has been confused with ventricular tachycardia. However, once the diagnosis is made it is one policy
of quinidine is nev
sician is familiar wit
properties of the drug,
traindications.

In treating ventricular t
the intravenous route. Qui
gm., is diluted in 150 cc. of s
tered over a period of 30 to
patient is observed carefully by
who remains at the bedside watchin
effects or changes in rhythm. If suc
they are immediately checked by means of
electrocardiograph. The dose may be repeated in 1 to 2 hours. When the condition is such that quinidine by mouth is decided upon the treatment is started with .2 gm. of the drug every two hours for five doses. The same plan is followed each day with an increase by .1 gm. per dose on each successive day. Rarely is it justified to give more than .7 gm. every two hours. It is obvious that such a plan of therapy precludes the existence of an emergency situation.

Intravenous quinidine has been administered

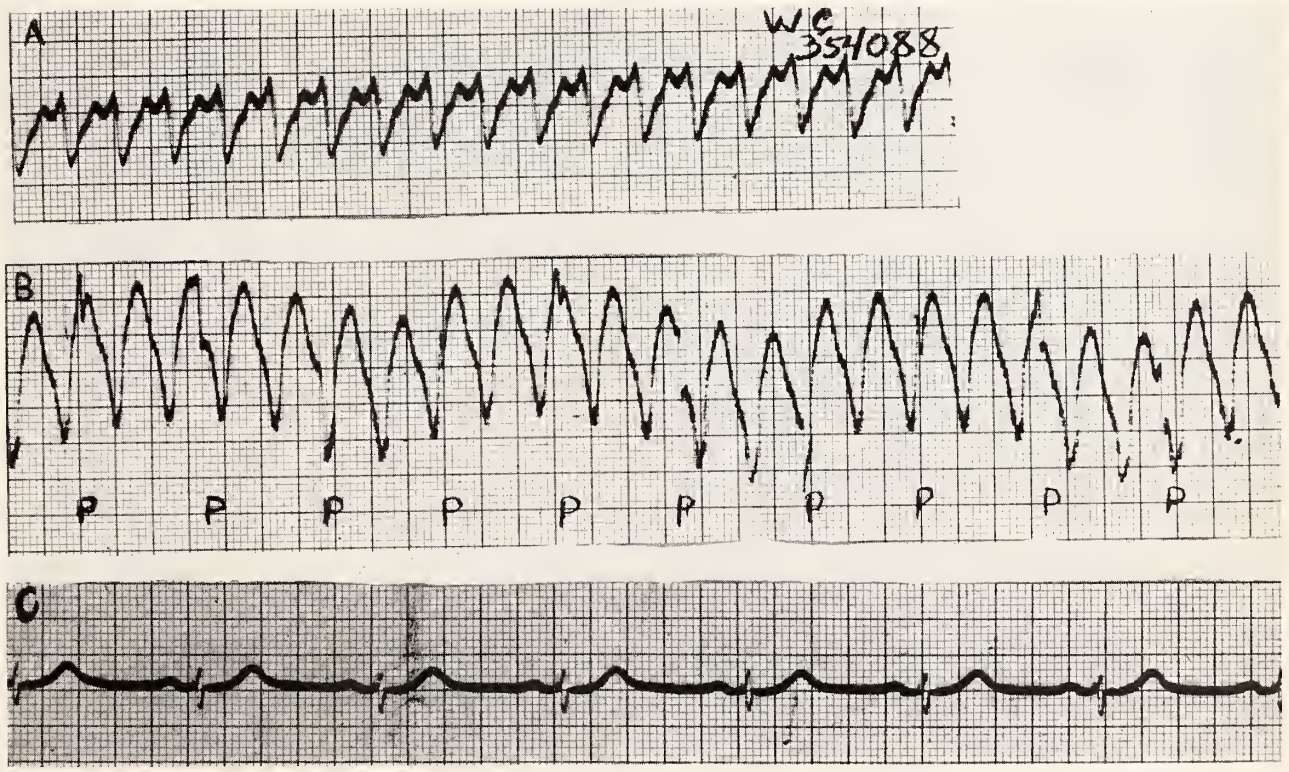


FIG. 5. A. Regular rate of 210 per minute. The complexes are aberrant suggesting ventricular tachycardia. Please note that these complexes (Lead II) do not differ from those observed in Lead II in figure 3 (auricular tachycardia with bundle branch block), stressing the difficulty in making a diagnosis of ventricular tachycardia.

B. Esophageal lead discloses independent P waves making a diagnosis of ventricular tachycardia a certainty.

C. Sinus rhythm was reestablished by intravenous administration of 1.2 gm. quinidine gluconate.

ents at the Indianapolis General
th gratifying results. We do not
recommend this form of treatment
one adheres to all safeguards as out-
ove.

SUMMARY

1. A brief outline of bedside diagnosis and emergency treatment of rapid cardiac arrhythmias is presented. Some of the statements regarding therapy may seem arbitrary. They are, however, based on combined experiences of those responsible for the management of the large number of such patients admitted to the Indianapolis General Hospital and are in agreement with the procedures followed in many other institutions.

2. Digitalis is the treatment of choice in the management of emergency situations arising from all forms of supraventricular tachycardia, except in those cases where digitalis is responsible for the arrhythmia. Digitalis should be administered by mouth. It is indeed a rare situation where the use of intravenous digitalis preparations is justifiable. In such cases the physician must assume the calculated risk of the route of administration as against the possible disastrous effects of continuing tachycardia.

3. Quinidine, in our experience, is the treatment of choice of ventricular tachycardia and other arrhythmias resulting from digitalis intoxication. In the latter situation supplemental potassium should be used.



This Month's Authors . . .

The following five case reports were written by resident physicians of Indianapolis General Hospital.

David G. Pietz, M.D., co-author with **Sheldon T. Pinsky, M.D.**, of the first report is now in practice in Bluffton. Dr. Pinsky is the present Krannert Fellow.

Franklin B. Peck, Jr., M.D., Robert E. Johnston, M.D., J. Paul Shields, M.D., and **Richard W. Dyke, M.D.**, are all residents in medicine.

Progressive Muscular Dystrophy with Involvement of the Heart

A CASE REPORT

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PROGRESSIVE MUSCULAR DYSTROPHY, a complex disorder of muscles and endocrine glands, can be a cause of cardiomegaly, congestive heart failure, and death.[1,2,3,4] Such a case is exemplified in the following case report.

This 31 year old colored male, Indianapolis General Hospital No. 307713, was asymptomatic prior to September, 1953, when he developed progressive epigastric distress, exertional dyspnea, and orthopnea. He was examined by several physicians, who remarked that he had a rapid heart. Chest X-ray (Fig. 1) taken on 10-4-53 showed slight cardiac enlargement and haziness in the lower lung fields, felt to represent pulmonary edema. The patient took digitalis for a short period, and experienced some relief while taking the drug. During the three month period from September, 1953, to December, 1953, he lost from 303 pounds to 282 pounds "because of being on a reduction diet." His past history was negative for hypertension, chest pain, and rheumatic fever.

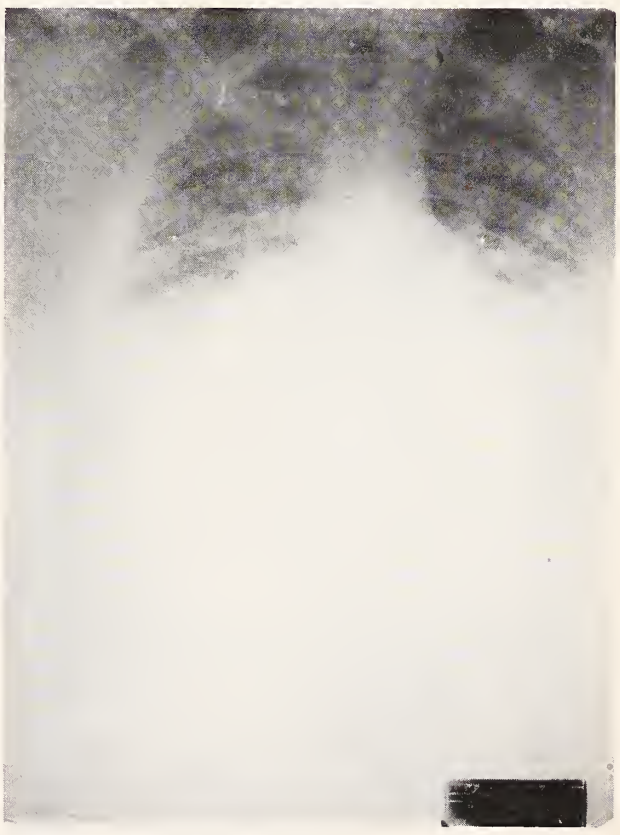


Figure 1. Description in text.

On December 30, 1953, he was first hospitalized. His main complaints then were right upper quadrant pain and dyspnea. Physical examination revealed blood pressure 130/100, pulse 100, and respirations 30/min. Lungs were clear. Examination of the heart revealed the P.M.I. to be 1 cm. outside of the midclavicular line in the 5th intercostal space, diastolic gallop rhythm, faint heart tones, and P2 greater than A2. No murmurs were present. The liver was tender and extended 5 finger breadths below the right costal margin. Two plus ankle edema was present. Cardiac fluoroscopy revealed generalized cardiac enlargement and weak pulsations. Electrocardiogram showed right axis deviation, and nonspecific T wave changes. For the first two weeks of hospitalization, the patient showed no improvement in spite of digitalization, low caloric, low sodium diet, and diuretics. Thereafter he did gradually improve so that by the time of discharge on February 5, 1954, his weight had fallen from 281 to 230 pounds.

Following discharge, he continued to have edema and moderate fatigue. He was given frequent injections of mercurial diuretics with poor response. One and one half months later, wasting of the upper extremities and face was

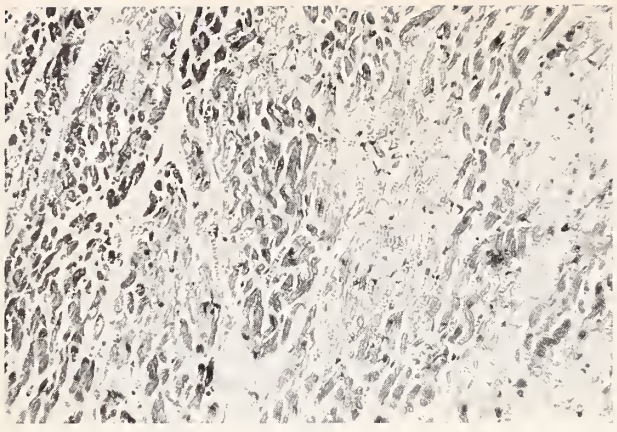


Figure 2. Description in text.

first noted. On direct questioning the patient stated that he noticed marked weakness of the legs, shoulders, and arms. On May 8, 1954, the patient was re-admitted to the hospital. Examination revealed a symmetrical atrophy and weakness of the shoulder girdle without much atrophy of the distal muscle groups. There was marked symmetrical softness and weakness of the pelvic girdle musculature. Reflexes were 1+ bilaterally. Blood pressure was 96/88, pulse 124/min. P.M.I. extended 3.5 cms. lateral to the midclavicular line, and a grade one systolic apical murmur was heard. No rales were heard. The liver was enlarged and there was four plus edema extending to the abdomen and lumbar area. A diagnosis was made of progressive muscular dystrophy with suspected dystrophic heart disease.

Laboratory data included hemoglobin 13 grams, normal WBC and urinalysis, Kahn 2+, VDRL 4+, bilirubin 4.4 mgm., chloride 75-105 mEq/L., and cholesterol 138 mgms.%. In spite of cardiac regimen, the patient's condition became progressively worse. He developed marked hyponatremia, oliguria, azotemia and finally died on June 1, 1954.

Postmortem examination revealed a very flabby heart weighing 520 gms. The cardiac muscle was pale in color and encircled with fat and showed some areas of scarring. There was no primary involvement in the valves, and the coronaries revealed moderate atheromatosis without calcification. The thickness of the right ventricle approximated the left, being 1.5 cms. The microscopic examination of the heart revealed areas of scarring with variable amounts of fat and connective tissue replacement (See Fig. 2). The muscle fibers underwent various degenerative changes including vacuolation, hypertrophy, with abnormal appearing nuclei and shrinkage. Oftentimes the myofibrils became widely spaced. Examination of the pectoral muscles revealed similar changes. The liver was enlarged and showed evidence of cardiac cirrhosis.

Cardiac findings at autopsy in this case were felt to be typical of dystrophic heart disease.

SUMMARY

An autopsied case of progressive muscular dystrophy with involvement of the heart is reported.

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Left to Right Ventricular Shunt with Pulmonary Stenosis

A CASE REPORT

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THE OCCURRENCE of left to right intraventricular shunt with coexisting pulmonary stenosis is quite uncommon. Abrahams and Wood[1] in a series of 700 cases of congenital heart disease found this condition in only eight instances (0.01%). Because of the rarity of this abnormality, the following case is presented.

CASE REPORT. C. H., #286842, was admitted to the Medicine Service of Indianapolis General Hospital with the presenting symptoms of severe shortness of breath. This 26 year old Negro male stated that he had been in good health most of his life. At 4 years of age a heart murmur was discovered which was thought to be functional. He was rarely ill during his childhood and adolescence and worked as a fireman on the railroad for the past several years. Approximately five months prior to admission he began noticing a "fluttering sensation" in his chest, lasting usually 2 to 3 minutes. This gradually became more frequent and was often associated with over-exertion. The fluttering was not severe enough to keep him from working. There was no dyspnea, orthopnea, or precordial pain associated with this presenting complaint, although he had experienced transitory tingling in the fingers of his left hand and a sense of precordial "distress" for one week prior to admission. During his childhood he contracted the usual contagious diseases and careful questioning failed to reveal a history of rheumatic involvement of any kind. Review of history by systems was completely negative, with the exception of epistaxis during adolescence. He is married and the father of three healthy children. None of his relatives had evidence of cardiovascular disease.

PHYSICAL EXAMINATION revealed an apparently healthy, alert Negro male. Average blood pressures were 106/64 for both arms and 140/90 in the lower extremities. There was no cyanosis before or after exercise, and no clubbing of the fingers or toes was seen. Positive physical findings were confined to the examination of the heart. No abnormalities of chest contour were noted. A visible pulsation was present in the third left parasternal space and a palpable thrill was present over this area. The point of maximum impulse of the heart was in the 5th intercostal space 2 cm. to the left of the midclavicular line. The heart did not appear enlarged upon percussion. Auscultation revealed a harsh grade IV systolic murmur heard over the precordium, but best at the 3rd left parasternal space. The second pulmonic sound was faintly heard.

LABORATORY RESULTS. Examination of the peripheral blood and urinalyses were within normal limits. Circulation time from arm to lung was 14 seconds and from arm to tongue was 33 seconds. X-ray and fluoroscopy of the heart revealed mild, generalized enlargement of both ventricles and of the right auricle. The pulmonary conus and pulmonary vasculature appeared to be within normal limits. No valvular calcifications were seen.

Electrocardiographic studies were within normal limits except for tall R-waves in V-1 and V-2 compatible with congenital heart dis-

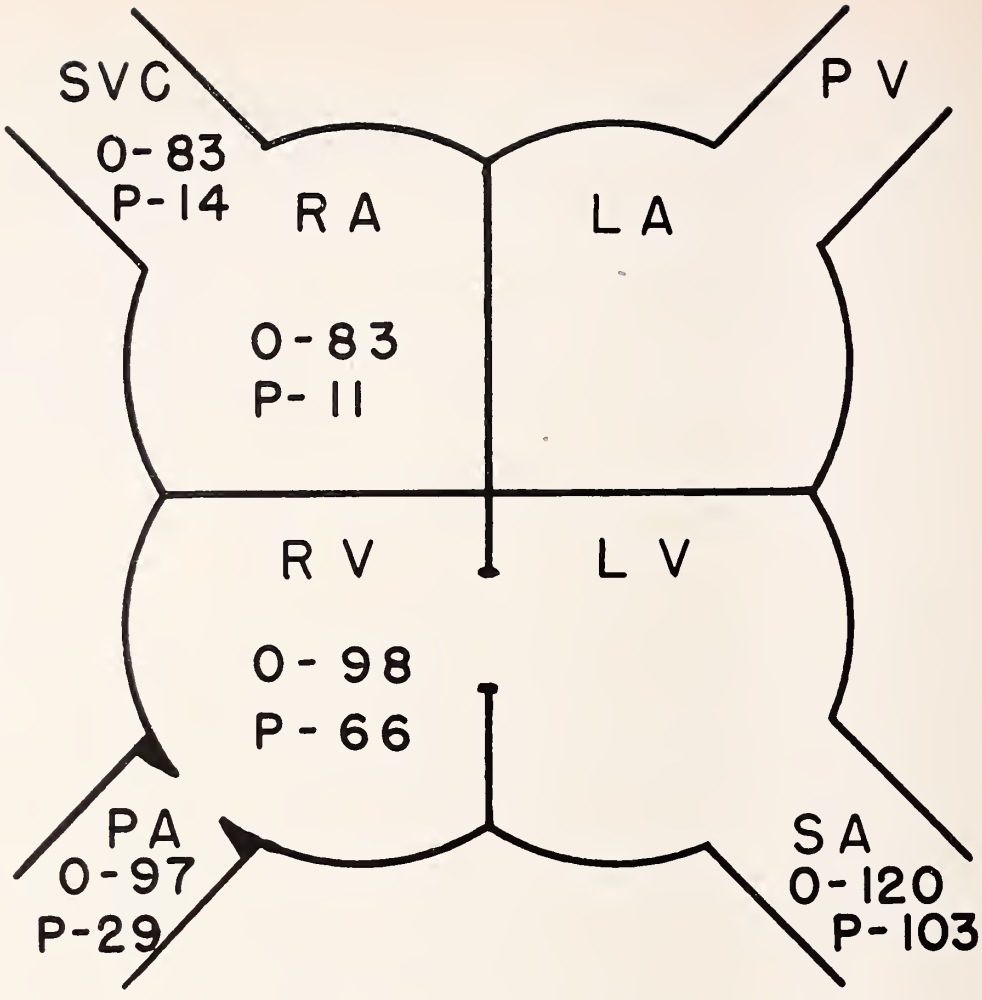


Figure 1

Diagram of results of cardiac catheterization
O=Oxygen saturation (percent of normal)
P=Pressure (mm Hg.)
SVC=Superior vena cava
RA=Right auricle
RV=Right ventricle
PA=Pulmonary artery
PV=Pulmonary vein
LA=Left auricle
LV=Left ventricle
SA=Systemic artery (radial)

ease of the type giving rise to right ventricular hypertrophy.

Cardiac catheterization was performed (Fig. 1) which revealed an increase in oxygen saturation of the right ventricle compared to the right auricle and superior vena cava. There was no evidence of peripheral arterial oxygen unsaturation. Pressure determinations revealed a definite increase in pressure of the right ventricle compared to the pulmonary artery pressure. These findings, i.e. an increase in oxygen saturation of the right ventricle with an increase in pressure of the right ventricle compared to the pulmonary artery pressure, and failure to find peripheral arterial oxygen unsaturation, were compatible with a diagnosis of left to right intraventricular shunt with pulmonary stenosis, and without an overriding or dextroposition of the aorta as seen in the tetralogy of Fallot.

The patient was subsequently released from the hospital to be followed on an out-patient basis.

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Application of Serum Glutamic Oxaloacetic Transaminase in Myocardial Infarction: A CASE REPORT

ROBERT E. JOHNSTON, M.D.

Indianapolis

B. J., a 44 year old white male, had been a known hypertensive for eight years. A diagnosis of essential vascular hypertension had been well established.

In September of 1955 the patient was admitted to Indianapolis General Hospital after an episode of sudden acute left anterior chest pain associated with abdominal bloating and dyspnea. These symptoms persisted for approximately 20 minutes and were immediately relieved by the passage of a large amount of flatus. When admitted the patient was pain free and asymptomatic. Physical examination was within normal limits except for an elevated blood pressure of 210/110 mmHg. Laboratory workup, including a serum glutamic oxaloacetic transaminase level of 20 units, was within normal limits. The patient was discharged on his third hospital day asymptomatic with a discharge diagnosis of hypertensive vascular disease.

After his first hospital discharge, the patient had several episodes of similar anterior chest pain, dyspnea, and abdominal bloating frequently associated with the ingestion of food but never with effort. Ten days after his previous discharge, the patient was again admitted with the same complaints as on his previous admission for further evaluation. Initial workup, including transaminase levels daily, white blood count and differential, and sedimentation rate were within normal limits. Electrocardiographic tracings were unchanged from those taken serially over the previous six months. During the first two hospital days the patient had two similar episodes of anterior chest pain and dyspnea relieved by nitroglycerin. On the third hospital day the patient again had an episode of dyspnea and left anterior chest pain which were not totally relieved by the use of nitroglycerin sublingually. The patient remained free of pain after one injection of morphine sulfate. Twelve hours after this episode the transaminase level was 135 units. A tracing taken at the same time as the blood was drawn for transaminase level showed electrocardiographic changes compatible with a posterior myocardial infarction. His WBC rose to 14,000; his sedimentation rate dropped to below his normal levels, and the patient manifested one degree of temperaure. A peak transaminase level of 160 units was observed 24 hours after infarction. The transaminase levels had returned to normal at the end of 68 hours. The patient responded satisfactorily to medical therapy until three and one-half weeks after the development of infarction when he began to have frequent episodes of dyspnea at rest occasionally associated with left anterior chest pain. This dyspnea and pain were relieved within two to three minutes by the sublingual use of nitroglycerin. Digitalization was initiated, resulting in a decrease in the frequency and severity of dyspnea and chest pain. Patient continued to have normal transaminase levels during the rest of his hospital stay. He was discharged six weeks after the development of myocardial infarction. Patient was maintained on anticoagulant therapy, digitalis, phenobarbital and pentaerythritol tetranitrate after discharge.

Thirteen days after his second hospital discharge the patient was again admitted to Indianapolis General Hospital because of more frequent episodes of severe dyspnea at rest usually without anterior chest pain. These at-

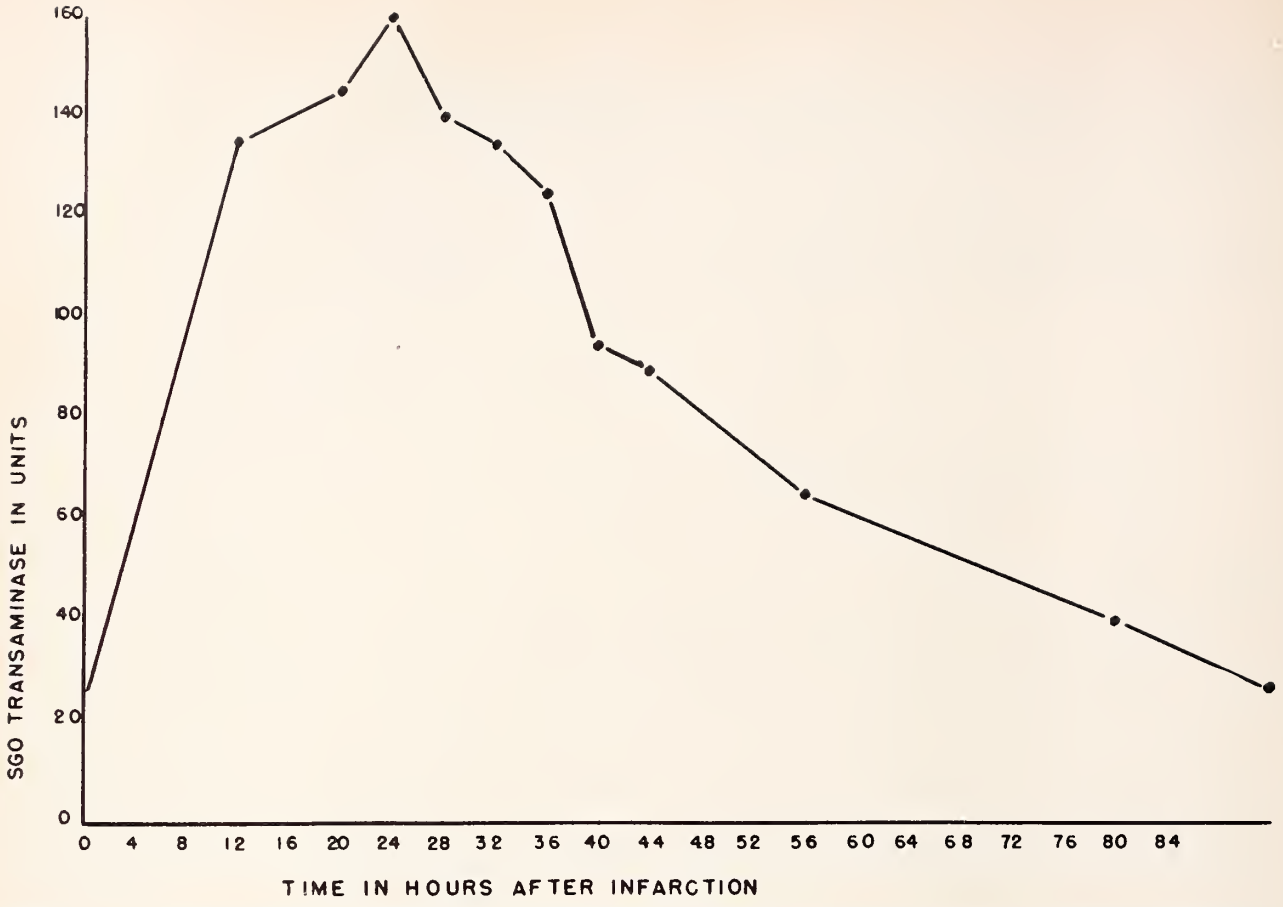


Figure 1. Serum glutamic oxaloacetic transaminase levels during patient's first myocardial infarction.

tacks of dyspnea were relieved in part, or totally, by sublingual use of nitroglycerin. An initial electrocardiographic tracing was unchanged from serial tracings taken after his previous infarction. During one attack of dyspnea shortly after admission an electrocardiographic tracing showed changes compatible with severe myocardial ischemia. These changes were transient and returned to normal shortly after the disappearance of dyspnea. A transaminase level was reported as 20 units. Sedimentation rate and WBC were normal. Prothrombin time was 30 per cent of normal. The patient was treated with Monotheamin suppositories, pentaerythritol tetranitrate, morphine sulfate, Dicumarol and Paveril Phosphate. Seventeen hours after admission he developed severe dyspnea associated with vomiting, became comatose, developed an arrhythmia and suddenly expired. At necropsy a small, well-healed posterior infarction was found. There was a fresh occlusion of the descending branch of the left coronary artery shortly after its origin, as well as gross evidence of a fresh myocardial infarction. All coronary vessels showed advanced atherosclerosis.

COMMENT

In this case report during two hospital admissions the transaminase determinations were helpful in differentiating severe coronary ischemia from myocardial infarction. This lends further support to the premise of LaDue[1, 2] that myocardial infarction and not ischemia causes elevations of transaminase levels. On his second hospital admission the diagnosis of myocardial infarction became apparent with approximate simultaneous appearance of electrocardiographic changes and an elevated transaminase level. Neither the electrocardiographic changes nor transaminase levels had been altered on the two days prior to the development of infarction. During the final hospitalization the transaminase level was normal in spite of severe myocardial ischemia with the patient expiring 17 hours after admission of an apparent sudden, massive myocardial infarction.

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Myxoma of the Left Atrium

A CASE REPORT

J. PAUL SHIELDS, M.D.

Indianapolis

PRIMARY TUMORS OF THE HEART are rare and the estimated total of reported cases is 300. The chemical and pathological findings of cardiac neoplasm have been reviewed by a number of authors.[1-16] In view of the rarity of the lesion the report of the following case seems warranted.

CASE PRESENTATION

A 54 year old Negro female admitted to the Indianapolis General Hospital on March 22, 1955.

Present illness began one month prior to admission with nausea, vomiting and diarrhea. Because of marked weakness and easy fatigue, patient had remained at bed rest. Dyspnea was present on the slightest exertion and ankles would swell during the day. Orthopnea and paroxysmal nocturnal dyspnea were absent.

Past history began in 1937 when difficulty in swallowing, cramping pains in epigastrium and "grunting respirations" after exertion had been noted. Patient was followed in the outpatient clinic from 1940 to 1947. During this time complaints were most often those of cramping epigastric pains and eructation. In 1944 complaints had begun to include chest pain, "racing" heart and marked weight variations. In 1946 shortness of breath, pounding heart, and a feeling that heart "flopped over" occurred and symptoms were gone in a few days. It began to be noticed that fast heart occurred after eating or exertion. In 1947 the patient began to have syncopal attacks. Physical examinations during this time were mostly noncontributory. On one occasion, however, in 1947, she was found to have a systolic murmur at the apex with classical findings of right sided failure. Failure responded to treatment with digitalis and diuretics. The patient was not seen again until present admission.

Malnourished colored female appearing chronically ill and lying flat in bed. Skin was dry with loss of turgor. BP 125/80-70; PR 84 reg.; RR 26; T-97.3. There were occasional inspiratory rales and decreased breath sounds in bases of both lungs. Heart examination revealed regular sinus rhythm without pulse deficit. Precordial thrust was prominent. No murmers or thrills were noted and pulmonic second sound was equal to aortic second sound. The liver was palpable at the level of the umbilicus, was firm, tender with irregular border. No other masses were felt. There was no edema of lower extremities.

LABORATORY DATA

Hgb—10.8; WBC—12,600; Neutro—66, band—4, lymphocyte—25, monocyte—5; urine—acid, SG—1.022, 1+ albumin, trace sugar, 150-160 WBC and bacteria. Chest X-ray disclosed cardiac enlargement with a "mitral configuration." The EKG revealed auricular fibrillation. No other significant changes were present.

HOSPITAL COURSE

On the day after admission the patient became unresponsive and presenting a picture of shock with Cheyne-Stokes respirations, cold extremities, apical rate 110 with extrasystoles. The lung fields were clear except for a few basilar rales and expiration wheezes, neck veins were distended and a large epigastric mass was palpable. EKG revealed auricular flutter with 4:1 block. Hematocrit was 40. Several examiners noticed that the pulsatile epigastric mass seemed to be enlarging. Patient continued to remain in shock,

developed moist rales in chest and died at 3:00 a.m., 3-24-55, 30 hours after admission.

Autopsy findings revealed bloody pleural fluid bilaterally, infarction of the right upper lung lobe secondary to thrombosis of right upper branch of the pulmonary artery. Right kidney was completely infarcted due to occlusion of right renal artery. There was an old infarct in the left kidney. The heart weighed 445 grams. There was a large, 8 cm. in diameter tumor filling the left auricle. Base of this tumor was 4 cm. in diameter and arose near fossa ovalis (Fig. 1).

Figure 1



The appearance of the tumor was one of a soft, yellow, gelatinous mass which contained hemorrhagic foci and areas of calcification. Valve leaflets were all considered normal and there was no evidence of infarction.

Microscopically tumor had a myxomatous matrix, was relatively acellular with occasional cells having stellate character, oval cells and a few with a spindle character. There was evident branching young capillaries. The base was covered with endothelium that was continuous with the endothelium of the endocardium.

DISCUSSION

Signs and symptoms leading to suspicion of tumor of heart are a short history, usually less than 2 years, with complaint of a shortness of breath, intractable congestive failure, transient apical diastolic murmur. Attacks of dyspnea relieved by lying flat with syncope in upright position should lead one to suspect this disease. Other features include narrow pulse pressure, X-ray with a mitral configuration, embolic phenomena, and sudden death.

The case presented is atypical in that the symptoms probably started not later than 1947 and may have started as early as 1940, although the information was too meager for a definite statement about the onset of illness. The symptoms of syncopal attacks, embolic phenomena not recognized antemortem, chest pain, transient cardiac murmurs, necessity of bed rest during

acute episodes, palpitation with exercise, marked dyspnea on exercise, arrhythmia, and the terminal episode could all be explained by the tumor of the left atrium.

SUMMARY

A case of myxoma of the auricle is presented and pertinent clinical features of the syndrome reviewed.

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Chronic Constrictive Pericarditis Associated with Rheumatic Valvular Heart Disease

A CASE REPORT

RICHARD W. DYKE, M.D.*

Indianapolis

THE FOLLOWING CASE is reported not with the intent to prove or disprove etiological relationship of chronic constrictive pericarditis and rheumatic heart disease but to add to the literature a report of the coexistence of the two diseases in one patient.

CASE REPORT

A white male was 63 years old at the time he was first examined by us in June 1951. His chief complaints were marked swelling of the abdomen and legs with difficulty in breathing while sitting up as well as when lying down and marked weakness. Significant past medical history dated back to 1913, at which time while working in a mine (his occupation for 30 years) the patient developed symptoms attributed to "flu". Upon arrival at the surface from the mine he collapsed. Peripheral edema, dyspnea, and orthopnea appeared. This illness forced six months bed rest after which work could be resumed. A similar but milder illness occurred again in 1937. The patient was well then until the fall of 1950 when fatigue, restlessness, peripheral edema, weakness, and abdominal swelling gradually appeared. He was studied thoroughly elsewhere and calcification of the pericardium as well as rheumatic heart disease was found. Strict cardiac management was then necessary. At least one member of his family had had tuberculosis.

Physical examination in June 1951 showed the patient to be acutely ill. Marked dyspnea, orthopnea and greatly distended neck veins were present. Evidence of fluid was present in the right posterior chest. Blood pressure ranged from 120/60 to 130/70 mm Hg. Precordial activity was not present. The PMI was found in the 6th left interspace in the anterior axillary line. Systolic retraction of chest was observed. The rhythm was one of auricular fibrillation. No murmurs were detected at that time. Ascites was so marked that adequate abdominal examination could not be carried out. No evidence of abdominal wall collateral veins was seen. Rectal examination was normal. Testes were atrophic. No spider angiomata were detected. There was 4 plus pitting edema of the legs up to the hips.

Laboratory data: Hemoglobin 9.8 gm/100 cc., RBC 3.49 M, WBC 7,000. Urinalysis: sp. gr. 1.011 with negative albumin and sugar, normal microscopic. Total serum protein was 5.6 grams/100 cc. with albumin 3.26 and globulin 2.34. Total protein of ascitic fluid was 1.15 gm/100 cc. BUN was 15.3 mg/100 cc. Electrocardiograms showed auricular fibrillation, digitalis effect, and later were also compatible with pericardial disease. Two weeks after vigorous therapy, fluoroscopy showed generalized cardiac enlargement, pericardial calcification, and pulmonary congestion. Subsequent study also indicated definite enlargement of the left auricle. After removal of 2,500 cc. of clear straw-colored ascitic fluid, venous pressure was 25 cm. water with marked elevation upon compression of the liver. The liver was then 4 cm. enlarged and firm. The spleen was palpable. Ether circulation time was 17.2 seconds and magnesium sulfate time was 31 seconds. Later a definite mitral diastolic murmur was detected. Cardiac catheterization was done and interpreted as compatible with constrictive pericarditis.

On May 22, 1952 the anterior two-thirds of

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the pericardium was resected. Following surgery it was possible to control edema and dyspnea with moderate restriction of sodium intake and infrequent mercurial diuretics without digitalis. However, for approximately one year prior to the last admission digitoxin and 0.5 to 1.0 gram sodium intake with frequent mercurial diuretics were used. The patient was admitted to the hospital for observation August 28, 1955 and in the early morning of August 30, 1955 marked dyspnea and cyanosis appeared with sudden death shortly thereafter.

Summary of the autopsy findings is as follows: The heart and attached pericardium weighed 850 grams. The pericardium was markedly thickened, fibrosed, and calcified throughout. It could not be separated from myocardium at any point.

The left ventricle was 1.7 to 1.9 cm. in thickness, the right ventricle 0.3 to 0.6 cm. The aortic valve was 7.5 cm. in diameter, the mitral valve 11 cm., the pulmonary valve 8 cm., and the tricuspid 14.5 cm. Both atria were markedly dilated. Coronary vessels could not be traced throughout because of the calcification. The mitral valve showed gross evidence of rheumatic disease, with rolled nodular fibrosed valve margins, marked shortening of the chorda tendineae and fusion of commissures. A moderate degree of stenosis with significant insufficiency was described. There were multiple fibrous adhesions between the diaphragm and liver and spleen as well as marked pleural fibrosis bilaterally. The mediastinum was a mass of fibrous connective tissue. Immediate cause of death was not evident. Microscopic examination failed to reveal evidence of active rheumatic disease of the heart; marked myocardial fibrosis was present throughout. Calcification was present in the heart muscle. There was marked fibrosis, calcification, and hialinization of the pericardium but no evidence of tuberculosis. Complete microscopic examination of all organs except the brain failed to reveal evidence of tuberculosis. The liver microscopically showed the type of change commonly seen with chronic congestive heart failure.

CLINICAL FEATURES OF CHRONIC CONSTRICTIVE PERICARDITIS[1]

Patients are usually children or young adults with dyspnea but not orthopnea unless pleural effusion occurs. Ascites and peripheral edema are the rule with distended neck veins in the upright position, the latter a feature very useful in differentiating this disease from primary cirrhosis of the liver. Frequently ascites appears before peripheral edema, existing for a long time alone or at least far out of proportion to the amount of peripheral edema. While the "classic" triad of Beck (small, quiet heart, elevated venous pressure, ascites and edema) is often observed, a significant number of patients are found to have moderately but definitely enlarged hearts. Venous pressure is consistently elevated despite treatment for congestive heart failure, and does not fluctuate as it does in the latter condition.

One third of the patients develop auricular fibrillation. Paradoxical pulse is present and pleural effusion frequently. However, just as frequently the chest is clear. Laboratory studies useful in making the diagnosis are electrocardiograms, x-ray and fluoroscopy, kymography and occasionally cardiac catheterization though the last is seldom necessary. Decreased minute output and stroke volume with inability to increase output per beat with exertion is the basic pathologic physiology resulting from restricted cardiac movement.

Constrictive pericarditis is one of the conditions to be considered in the differential diagnosis whenever a patient thought to have congestive heart failure fails to respond to treatment. The most frequent initial erroneous diagnosis is portal cirrhosis. Early removal of the thickened pericardium is the therapy of choice when coexistent myocardial disease is not present. Etiology when it can be definitely established is most often tuberculosis, yet there is some indication that rheumatic fever may be causative.[2]

SUMMARY

An autopsied case of chronic constrictive pericarditis associated with rheumatic valvular heart disease is presented. The etiology of the pericardial disease could not be definitely established though it was assumed to be tuberculous in origin.

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THE HEART IS THE ISSUE

EACH YEAR, in its February issue, The JOURNAL specializes a little in diseases of the heart and circulation. This is in recognition of the month of February as "Heart Month." The designation was originally chosen by cardiologists and heart associations in order to provide a definite time each year for the mundane task of soliciting funds for research into and treatment of heart disease.

By association the month has become a time of year for other activities such as postgraduate courses, seminars and special articles in the field of cardiology.

The JOURNAL is indebted to the staff members of the Robert M. Moore Heart Clinic for the group of papers which appear in this issue, with a foreword by Dr. Kenneth Kohlstaedt. The articles were written, as an integrated group, to present not only the well established concepts but also the newer developments in treatment of heart disease.

Just as the customs of St. Valentine's Day symbolize a state of the heart which ideally and customarily continues throughout the year, so it is hoped that this symposium on cardiology will be of practical value in the care of patients each day in the year in many a busy practice.

SCIENCE FAIRS AND MEDICAL SOCIETIES

THE AMERICAN MEDICAL ASSOCIATION is participating in the National Science Fair, next May 10 to 12, in Oklahoma City and will present a special citation to the high school student with the best medical exhibit.

The winner will not only receive the special AMA citation but will be invited to be a guest exhibitor in the AMA Scientific Exhibit at the Annual Meeting in Chicago June 11 to 15.

There are about 15,000 science clubs in the

high schools of the United States. Membership amounts to 350,000 students. Annual science fairs on a county, regional and national scale are a natural outlet for scientific interests and ingenuity. Some of the exhibits in the past have displayed inventive talent and research ability of the highest order.

All the science clubs are eager for sponsorship and assistance in organizing the science fairs. Medical societies fit into the picture most naturally because of the medical profession's basic interest in science and in education. A club spokesman declared:

"Science Fairs directly benefit the exhibitor, the sponsor, and the viewer by:

1. stimulating students to take a more active interest in the study of science

2. providing a proper means of recognition to young scientists

3. arousing interest of the public in the scientific ability of young people

4. giving an opportunity to see what others are doing in science."

The Science Clubs have always welcomed sponsors, but are especially elated by the interest and help which is afforded by the medical profession either as their only sponsor or in cooperation with other similar groups.

Of the 71 regional or state fairs last year, three were sponsored by medical organizations. Two of these were located in Indiana. The Lake, LaPorte and Porter County Medical Societies sponsored the Northwestern Indiana Regional Science Fair. The Indianapolis Medical Society sponsored the Central Indiana Science Fair.

The physicians who were directly connected with these enterprises were amazed at the interest which was shown, and without exception have recommended this type of community service as an interesting and rewarding medical society activity.

DROP IN ACUTE POLIO

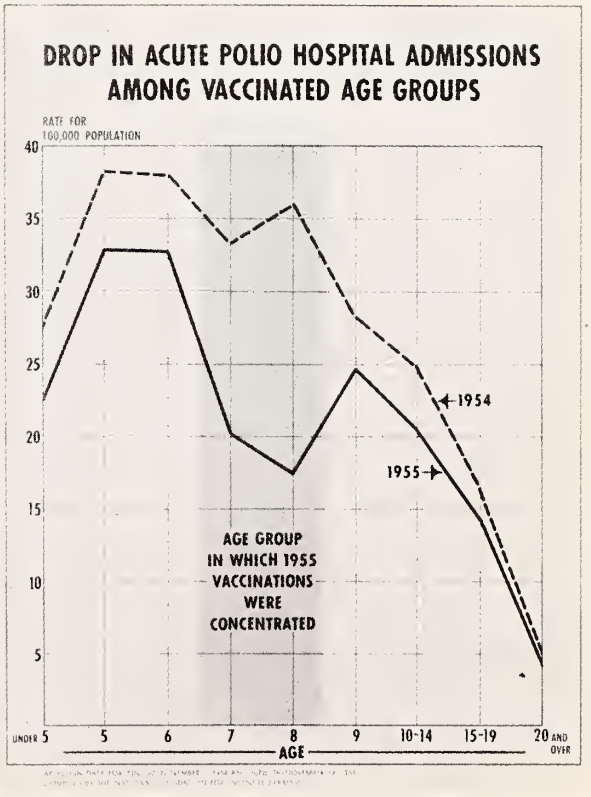
HOSPITAL ADMISSION RATES for polio in 1954 and 1955 were released in December by the National Foundation for Infantile Paralysis. The news is good. The figures suggest that there has been a decided decrease in paralytic polio in the age group which received most of the Salk vaccine.

The general incidence of poliomyelitis was less in the 11 reporting states in 1955 than it was in 1954. The two incidence graphs are practically parallel except for one significant difference. In the seven and eight year old group the 1955 graph presents a decided valley.

The rate for the eight year olds dropped 52 percent, for the seven year olds 40 percent, while the decline for the entire population was only 17 percent. For children from 15 through 19 years of age, not receiving vaccine, admission rates decreased only 12 percent.

Usually the rate for the seven and eight year old children is among the highest.

It is estimated that vaccine probably prevented between 1,200 and 1,300 cases of paralytic polio in the entire country. If the 11-state experience is found to hold for the entire 48 states, the expected incidence of 1,700 cases will have been reduced to 400.



BLUE CROSS

THERE ARE NOW in excess of 1,400,000 people in Indiana who are protected by Blue Cross.

Many members of the medical profession in Indiana practiced in the era before the establishment of a prepayment program by the hospitals. For these doctors the contrast between the times when patients were unable to enter hospitals because of financial embarrassment, and the development of Blue Cross with such a membership, is remarkable.

50,000,000 people, or roughly one-third of the population of the United States enjoy Blue Cross benefits.

In order to expand, or in fact in order to maintain its present position, Blue Cross must be able to do two things—remain solvent and hold its cost within the reach of most of the people. In spite of mounting hospital costs Blue Cross has achieved an outstanding financial feat, so far. However Blue Cross cannot create assets—all that it pays out on behalf of its members it must first collect from them. If the price becomes too high, only a few can afford it.

Now that prepaid hospital insurance has become almost universal it is in danger of being taken too much for granted, and everyone must be reminded that overusage of it may become its downfall. Its members and the medical profession need to be cautioned that the unnecessary hospital admission, the few days longer in the hospital, the convenient but not necessarily needful drugs and laboratory procedures are the things that, if uncontrolled, will do irreparable damage.

Blue Cross can grow larger only on a financial level which will include almost everyone. It has no future at a price which only the well-to-do can afford.

YOUTH

Youth is not entirely a time of life—it is a state of mind. It is not wholly a matter of ripe cheeks, red lips or supple knees. It is a temper of the will, a quality of the imagination, a vigor of the emotions, a freshness of the deep springs of life. It means a temperamental predominance of courage over timidity, of an appetite for adventure over love of ease. Nobody grows old by merely living a number of years. People grow old only by deserting their ideals. Years may wrinkle the skin, but to give up interest wrinkles the soul. Worry, doubt, self-distrust, fear and despair—these are the long, long years that bow the head and turn the growing spirit back to dust. Whatever your years, there is in every being's heart the love of wonder, the undaunted challenge of events, the unfailing child-like appetite for what next, and the joy and the game of life. You are as young as your faith, as old as your doubt; as young as your self-confidence, as old as your fear; as young as your hope, as old as your despair. In the central place of every heart there is a recording chamber; so long as it receives messages of beauty, hope, cheer, and courage, so long are you young. When the wires are all down and your heart is covered with the snows of pessimism and the ice of cynicism, then, and then only are you grown old.

—General Douglas MacArthur, in an address on his 75th birthday anniversary; quoted in *The Medical Bulletin (Doctors in Oil)*, March, 1955.

The President's Page

IT IS IMPOSSIBLE TO DENY that the great scientific advances of medicine have increased the costs of medical service. In the physical care of individuals, the same increase in hospital service is unavoidable. Present economic and social conditions have so modified the older customs of home care that the hospital has attained the status of a home when illness occurs. No longer is a hospital a place of last resort, no longer is it like the entrance to the galleys of France where an entrance sign said, "Abandon hope, all ye who enter here". Now, it is a place of hope and security and comfort. Its use is certain to increase and with that, a certain increase in medical costs will result. And those costs are so interwoven with costs of medical service that the public does not differentiate them.

The ancient and increasing use of diffusing costs by small contributions from many to meet the needs of the few is in line with good practice in business and thoroughly acceptable to the public.

The demands for national supply of such care arose solely from the costs, but were whipped into public emotion by starry eyed semi-socialists who looked only to ends, without adequate knowledge, because of the means. In 1946 and in 1950, the profession was faced by the apparent certainty of success of such catastrophic policy. It was argued that other nations had adopted such means, but they failed to observe the deterioration and they failed to remember that even a nation can be habituated into servile acceptance of low standards, in living, in politics, in culture, as well as in medical care.

We won that contest, but we would be simple if we think that a final result has been reached. The social reformers, who always desire to reform every one but themselves, have not abandoned their wrong and disastrous concepts. It thus becomes imperative that we do not relapse into our old complacency. Constant vigilance against "back door" approaches must be maintained. It is impossible to maintain political enthusiasm all the time. But to be able to bring into bearing, means a constant watchfulness by medical leaders and even more necessary, maintenance of a workable political unity among members of our profession. Such unity of action ought not be partisan, but organized to support or to oppose any given candidate for public office, especially national offices.

Senator Benton says, "Get into politics—You owe it to your community in a world where politics are increasingly determinant."

(Please turn to page 178)



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ACHROMYCIN*

Hydrochloride
Tetracycline HCl *Lederle*



widely prescribed because of these important advantages:

1) rapid diffusion and penetration
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The President's Page — (Continued)

Because our profession will be judged in large part by our deeds, not our advances in science, we must provide means for such advances to be available and provided by non-governmental sources, if our individualistic way of life is to continue.

Our chief, in fact, our only defense wall has been Blue Shield and Blue Cross. These have proven to be mighty defensive forces. The public has wholly approved of the methods, but there yet remains too large a section of the public not protected by Blue Shield and Blue Cross and similar methods. This approximate 50% of the population remains a challenge to our attempts to provide such protection, and until we have reached 80 to 90% of the whole people we must go on in active attempts to include them.

This campaign, now, is much more difficult because of costs, which when reflected in monthly contributions tend to be excessive, or rather, seem to be excessive until values are understood.

Our own Blue Shield and Blue Cross have skimmed the cream of low cost growth; industry offers large groups, insurable in mass, with excellent physical selection and age. We have in Indiana a field of some 2 million persons not presently carried; but they comprise individuals, recipients of public aid, and the medically indigent. Individual solicitation is quite costly and will result in resented charge increases.

Members of the Association may provide a readily available, and at no cost, method of helping to cover these groups, an effort aimed solely at the good of the people and with the certain end result of the good of the profession.

Blue Shield and Blue Cross offer kits of application cards and information which every Indiana physician should be willing to place in his waiting room. And it is so easy to make discreet inquiries of whether individuals carry such coverage along with the simple approval of the idea. It is not necessary to ring door bells or even to offer sales arguments.

In assisting in such programs, the physician is really protecting his own personal interest and income, as well as furnishing a service to his patient. It is not beneath the dignity of any doctor thus to serve his profession, his colleagues, the public, and his personal welfare.

W. U. Kennedy

The Women's Auxiliary

REPORTS TO I.S.M.A.

Greetings to all Doctors' Wives:

We are looking toward Spring and the coming 12th Annual House of Delegates which will be held in Gary at the Hotel Gary, April 26-27, 1956. It isn't too early to be writing for your reservations. The Gary and Lake County members are making plans for a large delegation and have many things up their sleeves for your entertainment. If you wish to come a day early let us know and we can plan a Chicago trip, to your specifications.

The Woman's Auxiliary to the State Medical Association, as you know, gives a one hundred dollar nurses' scholarship each year to a 4-H girl. It was my privilege to represent you at the Purdue Conference of 4-H boys and girls when awards were made. Our winner is a very charming and competent girl from Posey county. Lois Lanman, a senior at Mount Vernon High School, will enter nurse's training at the Deaconess Hospital in Evansville next year. The runner-up was so close that Miss Masten, from Purdue and one of the judges, felt that she too should be given a lift, so we contacted Tipton county where Virginia McNew lives and works in the hospital. Mrs. Boyd Burkhardt, president of the Auxiliary to the Tipton County Medical Society in consultation with other local women has graciously taken Virginia under her wing. So we are happy that both girls can look forward to achieving their ambitions.

We were glad to see so many from over the state at the Prepaid Insurance Committee meeting in Indianapolis on December 1. We were royally entertained, and were given a clearcut, understandable explanation of the need, reason and value of Blue Cross-Blue Shield Insurance by Mr. Converse. Remember, he invited each county Auxiliary to hold a similar meeting, with some time allowed for Auxiliary business, so if your group desires to be both entertained and enlightened get in touch with Mr. L. E. Converse at Blue Shield Headquarters, Indianapolis.

I wish to quote from the inaugural address of our National Auxiliary President, Mrs. Mason G. Lawson. She said, "The answer to many of our problems rests with you. Are you a part of the problem or a part of the solution to the problem? Will you assume your proportionate share of leadership in your own Auxiliary? Will you assume your proportionate share of health leadership in your own community, or will you be like Rip Van Winkle who went to sleep? A good leader learns to lead by leading. It is also true that each Auxiliary member is a leader and that she has a great influence on public opinion. She can, by her attitude, establish a pattern of thought towards the medical profession. Only you can make our dreams and hopes come true. Let each member resolve to make her own contribution, both to our Auxiliary and to the free communities in which we live."

Sincerely,

Helen W. Mather

Mrs. J. Winford Mather, President

Social Security Amendments of 1955

Following are two versions of the proposed amendments to the Social Security Act. Highly controversial provisions of the bill, H.R. 7225, are presented here as entered in the Congressional Record, Proceedings and Debates of the 84th Congress, First Session, Monday, July 18, 1955, pages 9277-9278. Speaking for the bill was the Honorable Jere Cooper (Dem.), Representative from Tennessee.

He said:

SOCIAL SECURITY AMENDMENTS OF 1955

Mr. COOPER. Mr. Speaker, I yield myself 8 minutes.

Mr. Speaker, H. R. 7225, the Social Security Amendments of 1955, would make several major improvements in the social security insurance system. In addition to extending coverage, the bill would remove inequities and shortcomings of the present system.

For years I have felt that a major shortcoming in the present insurance system is the lack of disability insurance benefits. It will be recalled that in 1949, the House passed a bill which would have provided such benefits. However, that provision did not become law. The pending bill would again provide such benefits.

The bill makes six changes in the old-age and survivors insurance program, and in addition contains certain technical amendments. I will now summarize the major provisions of the bill.

RETIREMENT AGE FOR WOMEN

The bill reduces from 65 to 62 the age at which all women may become eligible for benefits. This change would be effective for the month of January, 1956. Altogether, about 1,200,000 women would become eligible for benefits in January 1956. However, due to the fact that about 400,000 of these eligible women are working or are the wives of working men, about 800,000 will begin to draw benefits immediately. Of course, the 400,000 working women and wives of working men can draw benefits if their earnings or the earnings of their husbands should cease.

At this point, Mr. Speaker, I would like to bring to the Members' attention the fact that in the Appendix of the CONGRESSIONAL RECORD for Wednesday, July 13, 1955, I inserted a summary of H. R. 7225, beginning at page A5093. This summary sets forth not only the number of persons who will be benefited immediately and for several years in the future by this bill, but also the dollar amounts of their benefits. At this time I will not again go into these details which are contained in that summary.

DISABILITY INSURANCE BENEFITS

The bill provides for the payment of disability insurance benefits to permanently and totally disabled workers. No benefits would be provided for dependents of such workers.

In order to be eligible for these benefits, a worker must have attained age 50, be fully and currently insured, and have 20 quarters of coverage in the last 40 quarters which end with the first quarter of disablement.

It will be recalled that the social security amendments of 1954 provided for a freeze of the wage record of permanently and totally disabled workers so as to preserve their insurance rights. The pending bill would go one step further and would provide for the payment of disability insurance benefits upon a worker's becoming permanently and totally disabled.

The definition of disability for the purpose of paying such benefits is the same as that in present law in the freeze provision, except that

there would be no presumed disability for the blind. It will be recalled that under present law, disability is defined as inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which is expected to be of long continued and indefinite duration.

In the case where a worker is receiving State workmen's compensation or another Federal benefit based on disability, the disability benefit provided under the bill would be reduced by the amount of such benefit.

In order to promote the rehabilitation of a disabled worker, the bill provides that an individual who is performing services in the course of his rehabilitation under a rehabilitation program being carried out under an approved State plan would nevertheless be considered disabled for a year after the first rendered such services.

Disability insurance benefits would be payable for the month of January 1956.

CONTINUATION OF MONTHLY BENEFITS TO DISABLED CHILDREN AGE 18 AND OVER

Under present law, old-age and survivors insurance benefits for children cease upon their becoming age 18. The bill would provide for the continuation of benefits for permanently and totally disabled children after age 18 where they became so disabled before reaching age 18. The mothers of such children would also continue to be eligible for mother's benefits so long as they continue to have disabled children in their care.

In order to be eligible for benefits, a disabled child must have attained age 18 after December 1953, and must have been eligible for a child's benefit before reaching age 18.

These benefits would be payable for the first time for the month of January 1956.

About 1,000 disabled children would immediately become eligible for benefits, and each year in the future some 500 disabled children who attain age 18 would be continued on the rolls beyond age 18.

EXTENSION OF COVERAGE

The bill would extend coverage to all the presently excluded self-employed groups except physicians—in other words, lawyers, dentists, osteopaths, chiropractors, veterinarians, naturopaths, and optometrists would be given coverage. About 200,000 persons are involved.

It will be recalled that the President in his message on social security to the last Congress recommended that all professional groups be included. The bill which passed the House last Congress did include these same professional groups, with the same exception in the case of physicians.

About 20,000 workers engaged in the production of turpentine and gum naval stores would be covered, as well as 200 employees of the Federal home loan banks and about 13,000 Tennessee Valley Authority employees. These three groups were also included in the bill which passed the House last year.

The bill also, by enacting regulations under the present law, clarifies the status of persons who operate farms with the owners or tenants of those farms, under share-farming arrangements. This would be done by embodying present regulations which specify that these individuals are not employees but self-employed persons.

In addition, the bill provides that the present exclusion from self-employment earnings of rentals from real estate for social security purposes would not apply to income derived by an owner or tenant of farmland from the operation of a farm by another individual under an arrangement which provides for material participation by the owner or tenant in the farm production.

The new coverage provisions would be effective January 1, 1956.

Certain technical changes which affect coverage would be made in the Internal Revenue Code.

Employees of nonprofit organizations who were on the payroll of such organizations when the organizations elected social-security coverage but who did not themselves elect coverage at that time would be given a limited time in which to elect coverage. Nonprofit organizations would be permitted to acquire coverage for the quarter in which coverage is elected. Under present law, coverage becomes effective on the first day of the calendar quarter following the quarter in which coverage is elected.

District of Columbia credit unions would be made subject to the social-security tax. Their employees are already subject to the tax. This is a correction in present law.

CHANGES IN TAX RATES

As in the past, the Committee on Ways and Means in recommending the above-described im-

provements in the social-security insurance laws, has also recommended that the tax rates be increased so as to keep the Old-Age and Survivors Insurance Trust Fund actuarially sound. The bill provides for an increase in the tax rate of one-half of 1 percent on each, the employer and employee, effective January 1, 1956. The increase for self-employed persons would be three-fourths of 1 percent, since the self-employment tax is one and one half times the employee tax.

The scheduled increases in the tax rates on employers and employees would be increased by the same amount on each of the dates scheduled for increase under present law.

ADVISORY COUNCIL ON SOCIAL-SECURITY FINANCING

The bill provides for the periodic establishment of an Advisory Council on Social-Security Financing. The purpose of this council would be to review the status of the old-age and survivors insurance trust fund in relation to the long-term commitments of the social-security program each time before a scheduled increase in the social security tax rates.

This council would consist of the Commissioner of Social Security as Chairman, plus 12 other members to be appointed by the Secretary of the Department of Health, Education, and Welfare, representing, to the extent possible, employers and employees, in equal numbers, and self-employed persons and the public.

TECHNICAL AMENDMENTS

The bill would also make certain technical amendments. It would conform the Social Security Act with certain provisions of the Internal Revenue Code of 1954, which changed the deadline date for filing income-tax returns from March 15 to April 15. It would put computations involving disability periods on an annual basis. It would also preserve the relationship between Railroad Retirement and Old-Age and Survivors Insurance in the same manner as past amendments to the social-security laws have done.

CONCLUSION

Mr. Speaker, the proposed amendments contained in H. R. 7225 are not only sorely needed, but they are also sound. They remove inequities in the present system.

The most important improvement, in my opinion, is the provision of disability-insurance benefits for permanently and totally disabled workers. These workers are direly in need of protection.

The lowering of the eligibility age for women beneficiaries will help relieve the personal hardship encountered by older women who now have to wait until they are age 65 to receive benefits, since they will become entitled to them at age 62. It will also make it possible for working men to retire at an earlier age, since generally speaking, the wives of older working men are a few years younger than their husbands.

Providing for the continuation of monthly benefits to disabled children age 18 and over will recognize the fact that such children are just as dependent, and may indeed be more so, than children under age 18.

The extension of coverage provided in the bill will help close the gap in the protection of the system.

This is a very meritorious bill, and I urge that it be passed.

OPPOSED!

The following address on H. R. 7225 was presented before the American Medical Association, November 28, 1955, at Boston, Massachusetts, and later published as a special article in the January issue of Missouri Medicine. It is reprinted with special permission. The author of the *highly informative* article is the Honorable Thomas B. Curtis, St. Louis, Representative (Rep.) Second Missouri District.

He said:

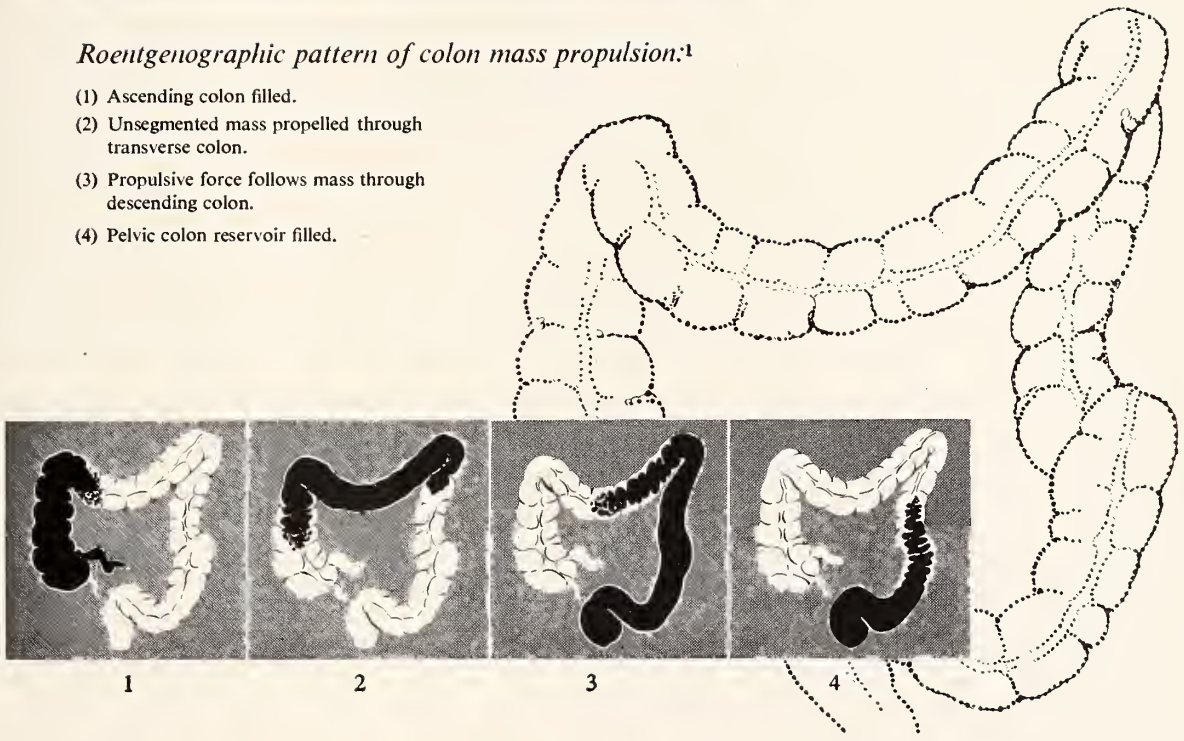
I am glad to be here to discuss with you the proposals to further extend the Federal Social Security System now pending in this Congress.

As you may be aware, the House of Representatives passed a bill this last session (the first session of the 84th Congress) extending the Federal Social Security System in various ways, the most important of which was the provision to make payment to disabled persons beyond a certain age. It does not specify the age itself because, once the theory is adopted by the Congress, the lowering of the age to include all

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.
2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

SEARLE

disabled persons is simply a matter of time.

Before I go into the details of this new proposal to provide disability payments, I would like to pause briefly to pay some attention to the procedures under which this new step in Social Security was taken. Regrettably, the people of this country no longer seem to care about the procedures under which legislation is written. At least, my colleagues in the Congress seem to think that the people no longer care about this fundamental phase of our government and, to date, regrettably, their thinking seems to be based upon reason.

Indeed, I wonder what the AMA thinks about orderly and proper procedures? Or any of our many, many groups concerned with Federal legislation? The rotten (that is the adjective I used on the floor of the House) procedures followed by the House of Representatives in considering legislation that would add two billion dollars a year to our Federal expenditures, met with little or no comment around the Nation.

I want to read to you the speech I made on the floor of the House on this matter. It may seem to veer off the subject of Social Security occasionally, but I think you will agree, on analysis, that it remains on the point.

"Mr. Speaker, of course, it is impossible to discuss the proposed liberalization of the social security program and the proposed financing of it in the time allotted under suspension of the rules. The Speaker knows this and upon his shoulders rests the responsibility of proceeding in such a fashion.

"Here I am opposed to this bill. I am opposed to these procedures, and I have been given three minutes to try to explain to this House just how rotten—and I use that word advisedly —how rotten the procedures were that we have followed in considering this piece of proposed legislation. I could not possibly explain it to this body in the time allotted—I trust the Members will give consideration to the procedures followed and determine for themselves whether they have the required soundness to produce good legislation.

"Hereafter follows the speech I wanted to make so that this body would have some idea of the unsoundness of the proposed legislation as well as the procedures followed. The speech would have taken ten minutes. As a matter of fact, less than ten minutes was available to the three Members of the committee opposing the suspension of the rules.

"The bill before us will cost around $2 billion a year for the next twenty years, after which it probably will cost $2.5 billion, assuming our present estimates are anywhere near correct. This is a gross assumption, I might add, because the very person making these assumptions warned the Ways and Means Committee in executive session that there was little to go on in making estimates concerning disability costs.

"The matter before us today is just incidentally the subject of social security. The real matter before us is the reputation of the Ways and Means Committee and the reputation of the House of Representatives. Judging from the experience I have just gone through as a member of the Ways and Means Committee, where all tried and true methods of procedure required for properly and adequately considering legislation were shoved aside by the power of the majority caucus, I have just a slight hope that the House will be any more concerned than it was about proper procedures.

"The issue facing the membership of this body is quite simple. Let me illustrate. A couple of days ago I was stopped outside the Chamber by two CIO leaders. One said: 'Well, I see you voted against social security.' I said, 'No, I did not vote against social security and you know it.' He said: 'Well, you voted against passing the bill out of committee,' I said: 'I certainly did, and I will vote against the bill on the floor of the House. But I am not against social security.' In fact, I believe I probably have done as much as any member of the committee to try to help the program and certainly have done considerably more than those Members of the majority—which was a majority of them—who attended no executive sessions, other than cursorily, to try to work out the problems as best we could under bad procedures.

"Certainly, anyone voting against the suspension of the rules here today will be branded by a vicious group of politicians as being against social security. That is the whole plan of what has been going on. Everyone here in the House knows it. But the fact that will be done neither makes it the truth nor does it mean that the people of this country or the people of any given congressional district will believe it, if the Congressman of that district will explain the true picture.·

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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"Last year, my colleagues, certain members of the Democratic Party, including the Speaker, took the floor to object to certain remarks which they interpreted to mean that the Democratic Party had been called a party of treason or a party that coddled communism. I added my small voice to this discussion, by condemning the actions of anyone who so stated or so intimated, because I felt that patriotism was a feature of a man's integrity and that there was no basis at all for attacking the integrity of the Democratic Party or any individual in it by such generalities.

"I took that position feeling deeply that for years certain leaders of the Democratic Party had been guilty of a grievous sin, for which they still do not apologize or desist from pursuing the sin of attacking the Republican Party and members of it by alleging a defect in integrity, which transcends even the virtue of patriotism. I refer to the virtue which is the essence of all Christian religion and of the Jewish faith—love of one's fellow man.

"Now here today, if you please, supposedly I am jockeyed into the position of either voting for this improperly conceived and studied bill in its entirety or of being branded as one not interested in the welfare of my fellow man. Now does anyone here deny that that is the essence of the procedures followed by our leftwing political element who have so long and too long, in my judgment, dominated American political thinking? Either you agree with their brand of government or you are against the people, against the little man.

"Now briefly to the bill itself that comes before us without any committee hearings to guide us, without the committee itself having called either in executive session or public hearings experts and others familiar with the various facets of this complicated proposal.

"What are the dangers and inadequacies? You can read the minority views in the committee report and get a brief résumé. I will only point up a few.

"First, reducing the age of women workers from 65 to 62 will create pressures to force women workers to retire earlier than at the present when the advancements of medicine have been such that our people can be gainfully employed longer, not shorter. And, in fact, for their very health they should be permitted the feeling of being economically valuable to their society.

"Both parties have endorsed the proposed equal rights for women provision of the Constitution. I am probably one of the few members of this body who has refused to sign a resolution following out this endorsement, because I feel that men and women are different—not one superior over the other—just different and yet in the area of retirement from work I see no difference. We are doing the women a disfavor, not a favor in this provision. Mind you, I am not talking about widows or wives of retired workers—the problems are different, and in these fields there are differences between men and women.

"Second, the proposed disability benefits have not been carefully considered. Our states and private enterprise, and, indeed, the Federal government, have made tremendous strides in the field of rehabilitation. Any disability program must be carefully geared into the rehabilitation programs or else the rehabilitation programs can be seriously damaged. No person in the rehabilitation field was even called before our committee to discuss the matter. In fact, in our committee were lengthy academic discussions of what the term "totally disabled" meant. I suggested we call some people from the Labor Department and from the rehabilitation field to go over this matter with us, because the term "totally disabled" is a term we are today beginning to feel applies to very few people. But our committee procedures were to hear no one, record nothing, pass all, previously decided in the know-nothing caucus of my Democrat friends of the committee.

"Third. The proposal to make share-croppers self-employed instead of employees as is now the law. How did that little gimmick slip into this liberalization bill? What discussion was had on it? What testimony? What is its effect? Well, I'll tell you what its effect is—thousands of southern share-croppers will probably no longer be included in social security. The owner running the operation will be relieved of his 2½ per cent tax. The share-cropper will be responsible for a 3¾ per cent tax. The owner will no longer be responsible for seeing that a return is made. The responsibility will rest on the share-cropper.

"Yes, indeed; it is important that this bill be brought out under a gag rule with no chance of amending. I wonder who in the CIO and A. F. of L. is responsible for this being in the bill or is this something that was needed to cement a deal?

"There are many good features in this bill. One of the best is the new fiscal responsibility. If we are going to increase benefits we must provide payment for the increase. But, as I said in debate last year on the extension of social security, do not let us kid the people about this program being either actuarially sound, fiscally responsible, or something that the people are paying for. The actuarial soundness, the fiscal responsibility, such as it is, is all based upon our children and our grandchildren—when we are the beneficiaries of the program—being willing to tax themselves 9 per cent of gross wages, 4½ for employer and 4½ for employee, 6¾ for the self-employed, as we so considerately say they shall, in our present legislation.

"But they are the ones who pay the bill. Not the people of today. We pay in our $1 and get out $3, our children and their children make up the $2 difference; that is, if the Congresses they elect go along with this program. I wonder if the Congresses they elect will have the courage to let these tax increases come about? Certainly judging by the recent Congresses since social security has been in effect the answer is an emphatic 'No.' And yet these Congresses have been representing people who got $10 for every $1 put in and more.

"And, finally, and fortunately for the country in one sense, and tragic in another, what we do today will not become the law of the land. All we are engaged in today is making a mockery of the House of Representatives and confirming the mockery already made of itself by the Ways and Means Committee. The Senate leaders have already announced that they intend to hold hearings on this bill. They have already stated that they are not going to abandon, just yet, at any rate, the time tested procedures that produce good legislation and protect against bad legislation.

"I am hopeful that there are in this body at least one third who feel the integrity of the House of Representatives and its committees is of sufficient importance to a free society that they will lay aside partisanship, will take their courage in their hands and vote against this gag procedure, and then take up the burden, and it is a burden, of explaining to their people just what the issues were on the floor today."

Now, gentlemen, the Senate will take this Bill up next session beginning in January 1956, be-



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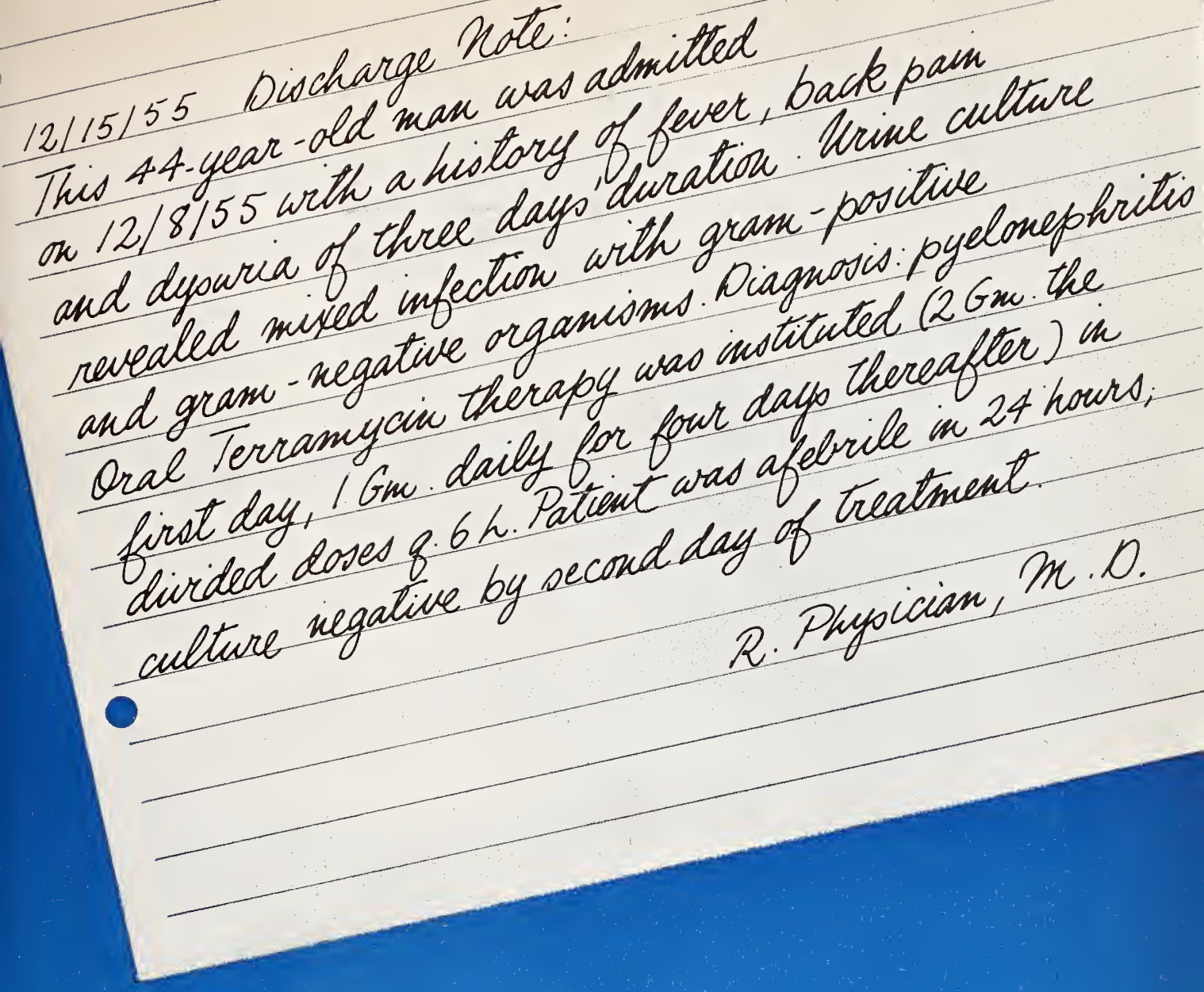
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cause there were not one third of the members of the House of Representatives who saw this issue as I did. I understand a real study will be made of the serious problems—aside from financing—that are involved in this seemingly simple matter of disability payments.

May I give this great organization some advice which I think is sound and basic? As you approach this problem, be certain that you make it quite clear that you are interested in and desirous of solving the problems that confront our disabled people. Otherwise you will soon find yourselves pictured—as have other groups on other subjects—as a group uninterested in human and social welfare unless you adopt the detailed program which these artists are promoting. In these days I am so reminded of the basic plot in the play of King Lear—the Tragedy of King Lear as it is properly titled. It is a simple plot. An old man was getting ready to retire and settle his estate on his three daughters. Before doing so, he asked the three how much they loved him. The first two had eloquent tongues and little integrity and told the old man what he wished to hear. The third daughter, perhaps a little disgusted with the outpourings of her sisters, was factual about her love and pointed out that she expected to get married some day and she would owe some of her love to her husband. We all know the sequel to this story, why it was a tragedy; the promises of the older two proved false and the disinherited third daughter, due to her banishment, was unable to save her father.

I suggest that this plot is an allegory. It is easy to tell the people of this present and voting generation how much we love them and all the things we will do for them. It is another thing to get up and say, but wait, we owe some love and allegiance to the coming inarticulate generation and we cannot pass all our love and consideration on to you. Will we, the American society, end up in tragedy because, like King Lear, we banish the thoughts and those who think and express them because we do not like to hear them? And banish them with a feeling of righteous indignation because we have not heard the words we wanted to hear of all-encompassing love for our own selfish generation? Banish them with a tinge of hatred in our souls because we choose to believe that those who express them have no love for the people, the little man, the common man?

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American people. That message must be carried above the din and the shouting of those who say they have all the answers; that these problems are not difficult to solve; that those who say there are difficulties in solving these problems are persons who are trying to thwart the will of the people and are setting up imaginary difficulties.

I could talk here today about the detailed problems of the Social Security System and we could have a serious consideration of them and, through this exchange of ideas, we would arrive at some correct solutions. But any discussion here is of no avail if the people believe that the American Medical Association is not interested in the welfare of the people—that the American Medical Association is not interested in solving the problems many of our people face in getting adequate health and hospital care—that the American Medical Association is not interested in moving on ahead to solve the still existing problems in the rehabilitation field and in the field of geriatrics, one of ever increasing significance.

Many Doctors say to me, "But surely you are wrong in thinking that the people of this country think the medical profession is uninterested in advancing the health and well-being of our people. Look at the advancements in medical care and treatment in this society of ours in the last decades." It is true that never in the history of the world has so much advancement been made in such a short space of time in the health and well-being of a people; it is certainly true that that advancement came through the efforts of our great medical profession and the system of political economics that exists in our society. Yet the people are listening to this wooing voice of professed love which says it is not enough.

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Let's get all the gold at once, let's kill the goose; those who keep the goose and want to preserve its life are merely trying to keep you from getting the gold. They are your enemies.

Where, indeed, has this world-turned-upside-down philosophy stemmed from? Where we find ourselves in an atmosphere where we cannot discuss things as honest human beings differing from each other, because our integrity has been attacked and we are branded as dishonest men?

Gentlemen, I do not believe I am overstating the case. Because of the forces set loose in our society, it becomes very important that you and other groups whose integrity has been cleverly attacked and smeared get the message to the people as fast as you can, that you do indeed love them, not a hypocritical statement, but an honest one like Cordelia's, but chasten yours by eliminating any feeling of annoyance you may have with the statements of the demagogues which have put you in the position of having to defend yourselves.

Not only will Social Security snowball beyond our powers to halt its running away, but it can start an avalanche in the over-all powers of the Federal government which may overwhelm us.

This Nation conceived in liberty and dedicated to the proposition that all men are created equal is by no means endowed with immortality. Abraham Lincoln was fearful that any nation so conceived and so dedicated could long survive, knowing full well that the cynical political philosophers had always maintained that such a nation given its own purse strings would spend itself to death. But in Lincoln's day political leaders would make their own decisions on the basis of the facts and arguments surrounding a problem and then report to the people the reasons for their decisions. Today the top political leaders devote their energies, not to leadership, but to trying to figure out what the people are thinking today on the immediate tomorrow. I have great faith, however, that when the American people begin to understand, as I see signs they are beginning to understand, the importance of representatives, not delegates, being in the Halls of Congress, they will act accordingly. Then I, with Lincoln, will assert my faith that this Nation under God shall not perish from the earth.

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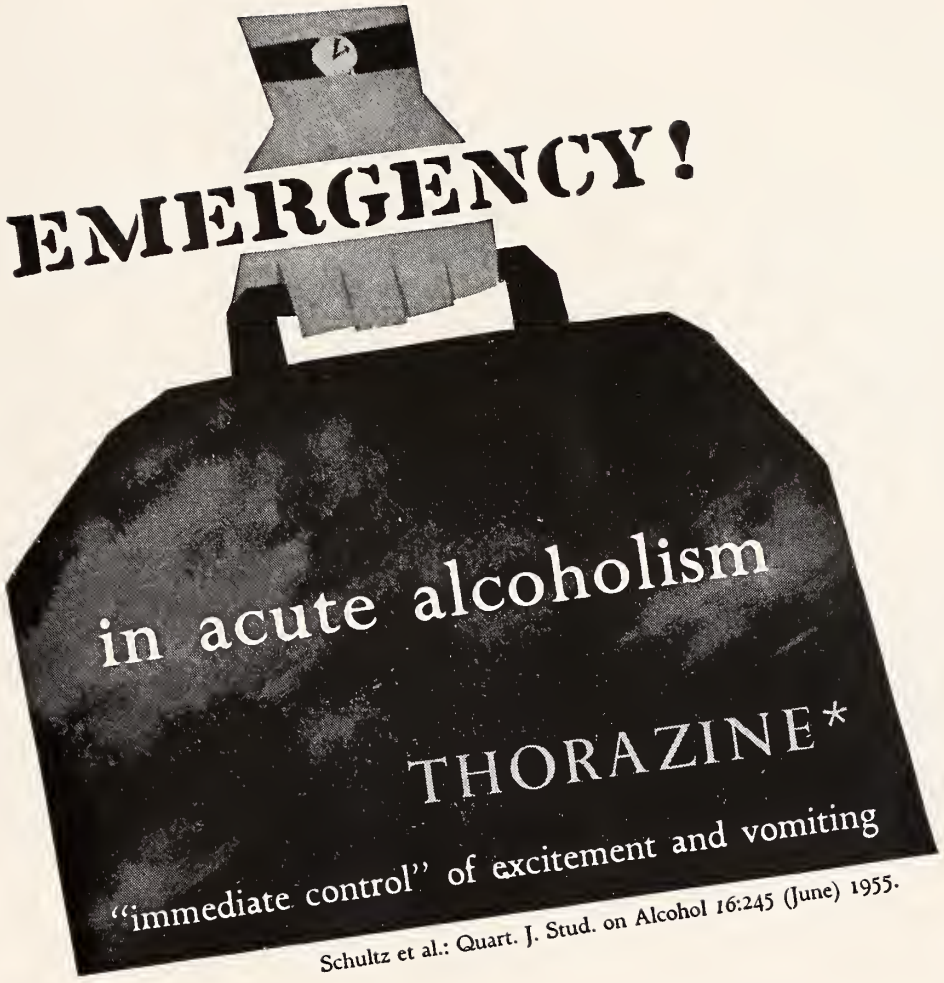
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THE INDIANA UNIVERSITY Department of Radiology is presenting a postgraduate course during the 10-week period beginning February 29 and continuing each Wednesday through May 2. "Clinical Uses of Radioisotopes" is the general subject. The course consists of 45 hours of lectures, laboratory demonstrations, clinical methodology and evaluations given on consecutive Wednesday afternoons (excluding March 28) between the hours of 1 and 6 o'clock (E.S.T.). Special laboratory exercises may be carried out by the participants in the isotope laboratories between 7 and 9 p.m. each Wednesday.

Previous knowledge of basic radiation physics is recommended but not required. Participants may obtain university certification of the course to present to the Allocations Branch of the Isotopes Division of the Atomic Energy Commission by meeting requirements outlined in application forms sent out previously to physicians.

COURSES OUTLINED

The first course February 29 will be in four parts:

1. Fundamentals of Radioactivity — Indiana University Staff
2. Types and Characteristics of Isotope Counting Equipment—Mr. John Kuranz, Chicago
3. Health Monitoring Equipment — Dr. Ernest Wakefield, Chicago
4. Techniques of Radiation Measurement—Mr. Wendell Bradley, Indianapolis

March 7 course includes:

1. Special Laboratory Techniques — Dr. F. W. Morthland, Indianapolis
2. Laboratory Design and Facilities—Mr. G. W. Morgan, Oak Ridge, Tenn.
3. Safe Handling of Radioactive Isotopes—Mr. G. W. Morgan, Oak Ridge, Tenn.
4. Radioisotope Dosimetry—Indiana University Staff
5. Physical and Biological Data on Medical Isotopes—Indiana University Staff

On March 14 the course concerns:

1. Diagnosis of Hyperthyroidism with I-131—Dr. Charles Owens, Mayo Clinic
2. Immediate and Continuous Uptake Studies of I-131 in the Diagnosis and Treatment of Hyperthyroidism—Dr. Sol Taplits, Cincinnati
3. Diagnosis of Other Thyroid Disorders with I-131—Dr. Owens
4. Thyroid Profile and Scanning Techniques with I-131—Dr. Arthur Hobbs, Evansville
5. Demonstrations—Indiana University Staff

Lecturers for the other courses, concluding the series, will be listed with a subject outline in the March issue.



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Eight Distinguished Authorities to Present Symposium on Malignancy

DIAGNOSIS AND TREATMENT of intracranial neoplasms in children and adults will be emphasized at the ninth annual Symposium on Malignancy, being presented March 27-28 by the Indiana University School of Medicine. The symposium, open to all physicians, is again presented with the support of the Indiana Cancer Society.

The program this year will be presented by eight visiting speakers, each a recognized authority on various phases of the subject. Included are: Dr. Percival Bailey, Distinguished Professor of Neurology and Neurosurgery, University of Illinois; Dr. Reginald Bickford, head of the electroencephalographic laboratory, Mayo Clinic; Dr. Douglas Buchannan, pediatric neurologist, University of Chicago; Dr. Harold O. Peterson, radiologist, University of Minnesota; Dr. William Peyton, Chief of Neurosurgery, University of Minnesota; and Dr. H. N. Zimmerman, Chief of Laboratory Division, Montefiore Hospital, New York City.

The eighth guest speaker is Dr. Joseph B. Pennybacker, Oxford, England, a Fellow of the Royal College of Surgeons and neurosurgeon at the Radcliffe Infirmary and London Hospital.

The symposium opens this year with a clinical pathological conference on Tuesday evening, March 27, when two cases will be discussed by the speakers. Wednesday (March 28) morning and afternoon sessions will also be held in the Medical School auditorium with each of the speakers participating. Individual topics will cover the pathology, diagnosis and treatment of intracranial neoplasms, including use of such diagnostic aids as X-ray, electroencephalograms, and radioactive isotopes.

The Symposium on Malignancy was inaugurated as one of the growing number of post-graduate presentations of the School of Medicine, with a different phase of malignancy emphasized each year. In recent years the programs have dealt with cancer of the breast, the lung, the cervix and the genito-urinary tract.

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(1) Poyne, R. W.; Shetlor, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmoel, W. K.: J. Lab. & Clin. Med. *45*:331, 1955. (2) Bunim, J. J.; Willioms, R. R., and Black, R. L.: J. Chran. Dis. *1*:168, 1955. (3) Holbrook, W. P.: M. Clin. North America *39*:405, 1955.

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Deaths . . .



Eldridge M. Shanklin, M.D., editor emeritus of The JOURNAL of the Indiana State Medical Association, died January 5 at St. Margaret's Hospital, Hammond. He had been ill for several years.

Doctor Shanklin had served in many of the top offices of his county, district and state medical organizations. He was editor of The JOURNAL from 1933 through 1948 when the Council of Indiana State Medical Association named him editor emeritus for life. Previously, in 1925, he was president of the State Association, and was chairman of the Council from 1921 to 1924.

Doctor Shanklin was born in Carroll County in 1875, attended Hanover College and the Medical College of Indiana where he received his degree in medicine in 1902. He established his practice in Hammond in 1903 where for many years he specialized in ophthalmology. He retired in 1952.

He served as secretary of Lake County Medical Society for several years and was also president of that group. In 1911 he began his long service to the State Association. Through the years he was on numerous committees, was Tenth District Councilor for 10 years, chairman of the Council and President. He was a delegate to I.S.M.A. and to the American Medical Association, and was a member and president of the State Board of Medical Registration and Examination for a number of years. Doctor Shanklin also was a member of the Advisory Board of the Cooperative Medical Advertising Bureau of A.M.A. He was one of the founders of the Indiana Academy of Ophthalmology and Otolaryngology, and of the Lake County Medical Society.

In addition to his medical affiliations Doctor Shanklin was a past officer of Masonic groups, a charter member of Hammond Rotary, and a former exalted ruler of his Elks Lodge.

John T. Kime, M.D., 89, who was Indiana's Physician of the Year in 1952, died December 10 in Good Samaritan Hospital, Vincennes. He had practiced medicine in Petersburg for 66 years.

Dr. Kime was a native of Pike County and the son of a physician. His early training was obtained by assisting his father in the preparation of medicines. He attended the University of Michigan Medical School for two years and then transferred to the University of Louisville School of Medicine where he received his degree in medicine in 1889. He established his practice in Petersburg immediately and called on his first patient after midnight of the first day. Dr. Kime frequently remarked that throughout his career he had always practiced on a 24-hour basis.

Dr. Kime held each of the offices of the Pike County Medical Society on several occasions, and was a 50 Year Club and senior member of the Indiana State Medical Association.

Charles W. Atkinson, M.D., 77, Boswell physician for many years, died in his home December 24 from a cerebral hemorrhage.

Dr. Atkinson was born near Plainfield. He received his degree in medicine from the Medical College of Indiana, Indianapolis, in 1903. After practicing in New Ross for one year, Dr. Atkinson established his practice in Boswell in 1905 and had served that Benton County community as a general practitioner since. He was county health officer for many years.

Dr. Atkinson was a senior member of the Benton County Medical Society, and a Fifty Year Club member of Indiana State Medical Association.

Sayers J. Miller, M.D., 57, director of the Student Health Service at Purdue University,

died suddenly of a heart attack on December 18 in his West Lafayette home.

Dr. Miller was a native of Indianapolis, attended Butler University and received his degree in medicine from Indiana University School of Medicine in 1924. He joined the Purdue Student Health Service staff in 1926 and had been director of the service since 1935.

For 30 years Dr. Miller had been active in affairs of the university, lodge work and service club programs. He was a member of Tippecanoe County Medical Society, the Indiana State and American Medical Associations. He served as 1955 president of the Indiana College Public Health Association.

Orlando Curtis Wicks, M.D., 86, died in his Gary home December 24 following a month's illness. He was Lake County's oldest practicing physician.

Dr. Wicks was born in Baltimore and began his career as a school teacher. He was graduated from the University of Michigan Medical School in 1902 and practiced first in Muskegon, Michigan. He had been in Gary for 47 years.

In addition to his devotion to his practice, Dr. Wicks served several terms as an elder in his church, and was a charter member of Gary Masonic lodge.

In 1952, Dr. Wicks was made a member of the Emeritus Club and honored for his 50 years in medicine by the University of Michigan and in 1953 the Indiana State Medical Association presented him with a certificate of distinction in recognition of his half-century as a practicing physician.

He was a senior member of Lake County Medical Society and the Indiana State Medical Association as well as a Fifty Year Club member of the latter association.

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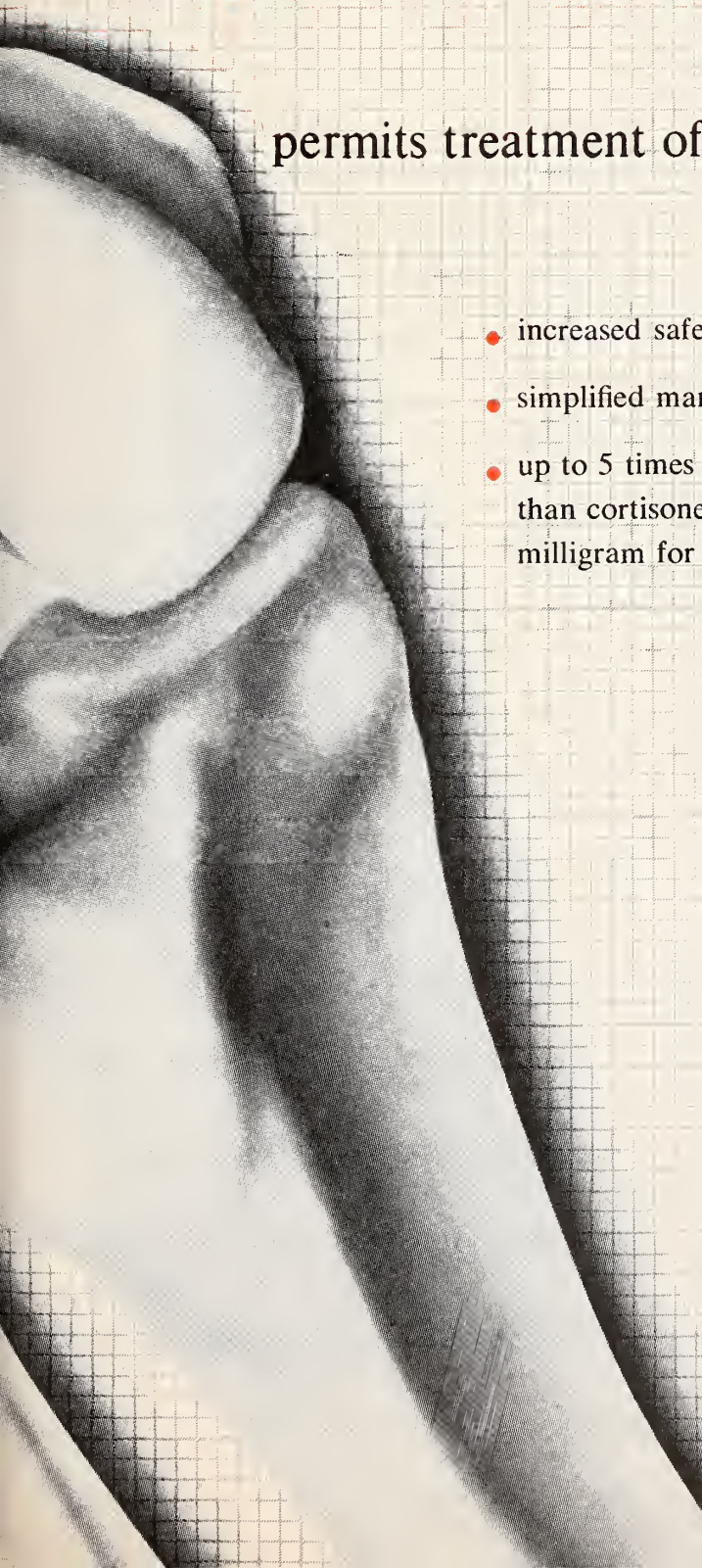
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NEWS NOTES — from State and Nation

Indiana Division, ICS, to Meet at Medical School March 21

The annual meeting of the Indiana Division, of the United States Section, International College of Surgeons, will be held March 21 in the Clinic Building auditorium at Indiana University School of Medicine. All physicians are invited and there is no registration fee.

Dr. Emmett B. Lamb, president of the Indiana Division, said, "A really fine program has been planned and we believe it will appeal to all physicians regardless of specialty."

The program will open at 10 a.m. with a 2-hour wet clinic. Luncheon will be served from 12 noon until 1:30 in the Student Union Building.

The afternoon and evening program follow:

1:30-2:00	Surgical film
2:00-2:45	Dr. Alfred Whitaker, Detroit "Emergency Treatment for the Seriously Injured"
2:45-3:30	Dr. John DeJ. Pemberton, Mayo Clinic, Rochester "Nodules of the Thyroid Gland, Their Significance and Management"
3:30-4:15	Dr. Chester Guy, Chicago "Present Status of Surgery for Duodenal Ulcer"
6:30	Cocktail hour
7:00	Dinner, Riley Room, Claypool Hotel

The banquet speaker will be Dwight H. Murray, M.D., president-elect of the American Medical Association.

Dr. Alan L. Sparks, Indianapolis, will present a paper on "Cancer of the Middle Ear in Patient With Long Standing External Otitis" at the American Medical Association Convention in Chicago June 12-14, according to an announcement issued by Dr. Hugh A. Kuhn, Hammond, secretary of the Section on Laryngology, Otology and Rhinology of A.M.A.

Dr. C. Basil Fausset, Indianapolis, presented a paper on "Neurosurgery" before a recent meeting of the Anderson Business and Professional Women's Club.

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Research Grants Renewed by AEC to I.U. Foundation

The Atomic Energy Commission has announced the renewal of research grants to Indiana University Foundation for continuation of research in biology. Dr. H. J. Muller will continue his work on the influence of radiation in altering the incidence of mutations in drosophila. Dr. Roy Repaske will work on energy transport in bacterial cell-free extracts.

Dr. Wallace S. Tirman, South Bend, has been elected a Fellow in the American College of Radiology, an announcement from ACR headquarters in Chicago discloses. Investiture services were scheduled for February 10 at the Drake Hotel, Chicago, as a highlight of the annual meeting of the College and Conference of Teachers of Clinical Radiology.

Dr. Kenneth R. Woolling, Indianapolis, was officially certified as a specialist in cardiovascular diseases by the American Board of Cardiovascular Disease November 30.

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"Clinical Reviews" Program Announced by Mayo Staff

A 3-day program entitled "Clinical Reviews" will be presented April 9, 10 and 11 at Rochester, Minnesota. The presentations will be given by staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research. The meeting will be devoted to lectures and discussions on problems of current interest in general medicine and surgery.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota. There are no fees of any kind.

Dr. W. A. Johnson, Perrysville, returned recently from a 16-day Caribbean cruise during which time he was enrolled in a Drake University postgraduate course held on board ship.

Dr. Harold D. Hill was reappointed Wayne County coroner on his return from army service in November. His term as an elected official was interrupted when he was recalled into service. The post was filled by **Dr. John H. Mader,** also of Richmond, during Dr. Hill's absence.

The University of Oklahoma has appointed **Dr. Herbert Kent** as associate professor in the Department of Physical Medicine, University of Oklahoma School of Medicine, Oklahoma City. Dr. Kent was formerly associated with the Indianapolis VA Hospital.

Medical Center Exhibit Winner at AAOG Meeting

A scientific exhibit on "Management of Severe Preeclampsia and Eclampsia" won second place award at the Fourth Annual Clinical Meeting of the American Academy of Obstetrics and Gynecology in Chicago December 12-14. The exhibit was the work of Drs. Dan B. Kahle, Carl P. Huber, and Charles Gillespie, Indiana University Medical Center and General Hospitals, Indianapolis.

More than 1,700 members attended the meeting which attracted 30 scientific exhibits and 98 technical exhibits. Dr. Ralph E. Campbell, professor of obstetrics and gynecology at the University of Wisconsin School of Medicine, was named president of the AAOG and dates for the 1956 meeting will be November 7-9 at the Palmer House, Chicago.

Dr. Clarence G. Kern, Lebanon, has been elected president of the Lebanon Kiwanis Club. Dr. Kern has been active for several years in Kiwanis programs for underprivileged children.

New members of the Decatur City Board of Health are **Dr. Norval Rich,** named to fill a three year term, and **Dr. Arthur Girod,** appointed to a four year term.

Dr. Charles B. Williams, who was in practice in Huntingburg for several years, recently purchased the office of Dr. G. D. Larrison at Morocco where he is now practicing. Dr. Williams, a 1942 graduate of Indiana University School of Medicine, served two years during World War II and also two years during the Korean war. He served his internship at Toledo and has had special training in surgery and obstetrics. Mrs. Williams, a registered nurse, assists him.

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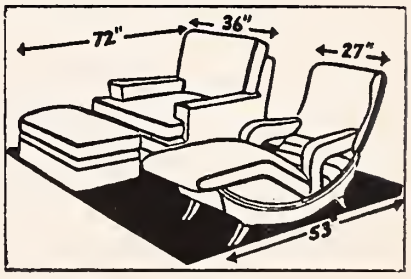
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News from the County Societies

Bartholomew-Brown County Medical Society's annual meeting was held December 14 in the Harrison Lakes Country Club near Columbus with 23 members present for the election and program.

Following dinner, officers' and committee reports for the year were presented and a report was given by the I.S.M.A. field secretary.

Officers for 1956 were elected as follows: Dr. Marvin R. Davis, Columbus, president; Dr. Howard E. Rothring, Columbus, reelected vice-president; Dr. Eleanor Clay, Columbus, secretary-treasurer. Dr. Robert M. Reid was re-elected delegate to the state convention and Dr. Lowell F. Beggs, alternate. Dr. W. S. Fisher was elected to the board of censors.

The program for the meeting, dealing with Civil Defense and disaster planning, was presented by Dr. D. C. Smith, chairman. He reported on development of plans for disaster aid and the assignment of doctors to various medical units. Dr. George W. Ritteman discussed radiation hazards and medical treatment in event of atomic attack.

Twelve members of **Boone County Medical Society** held an evening business meeting in Witham Memorial Hospital, Lebanon, January 3. The date of their next meeting was set for February 7.

Older members of **Cass County Medical Society** were honored guests at a dinner meeting December 19 in the Ben-Hur Restaurant in Logansport. Guests of honor were Drs. John B. Maxwell, Logansport, who is 96 years old; John C. Bradfield, William A. Holloway, Foss Schenck and Milton B. Stewart, all of Logansport, and Dr. E. P. Flanagan, Walton.

The speaker was Dr. E. L. Hedde, Logansport, who discussed "Recent Advances in Medicine."

Forty-six persons attended the affair, including members, wives and special guests.

Officers for 1956 are: Dr. Earl W. Bailey, president; Dr. R. J. Morrical, vice-president; Dr. B. E. Fitzgerald, secretary-treasurer; Dr. L. J. Hillis, delegate; and Dr. E. L. Hedde, alternate delegate. All are Logansport physicians.

Clark County Medical Society officers for 1956 will be Dr. Alan Willner, Clarksville, president; Dr. George Buehler, Jeffersonville, vice-president; Dr. H. S. Shina, Charlestown, secretary-treasurer; and Dr. John S. Huoni, Jeffersonville, delegate. The annual election took place on December 20.

The **Clay County Medical Society** met in the Brazil Elks Club December 20 for dinner with 11 present.

Officers for 1956 were elected after the dinner. The following will serve as Clay County Society officers: Dr. Robert M. Maurer, Brazil, president; Dr. Wilbur McCormick, Brazil, vice-president; Dr. John M. Palm, Brazil, secretary-treasurer and delegate; and Dr. Jack R. Glosson, Clay City, alternate delegate.

Members of **Clinton County Medical Society** elected Dr. J. A. Van Kirk, Frankfort, president for 1956 at a December 20 meeting. Other officers chosen were Dr. Fred Flora, Frankfort, vice-president; and Dr. Frank A. Beardsley, Frankfort, secretary-treasurer.

At a noon luncheon meeting December 19 members of **Davies-Martin County Medical Society** elected 1956 officers and discussed attendance and insurance problems. Eight members attended the meeting in the Daviess County Hospital in Washington.

Dr. L. M. McNaughton, Washington, was named president; Dr. M. H. Seat, Washington, vice-president; Dr. C. Philip Fox, Washington, secretary-treasurer and delegate to state convention; and Dr. Robert H. Rang, Washington, alternate delegate.

A report of the proceedings of the A.M.A. House of Delegates and several current problems were given by R. J. Amick, field secretary.

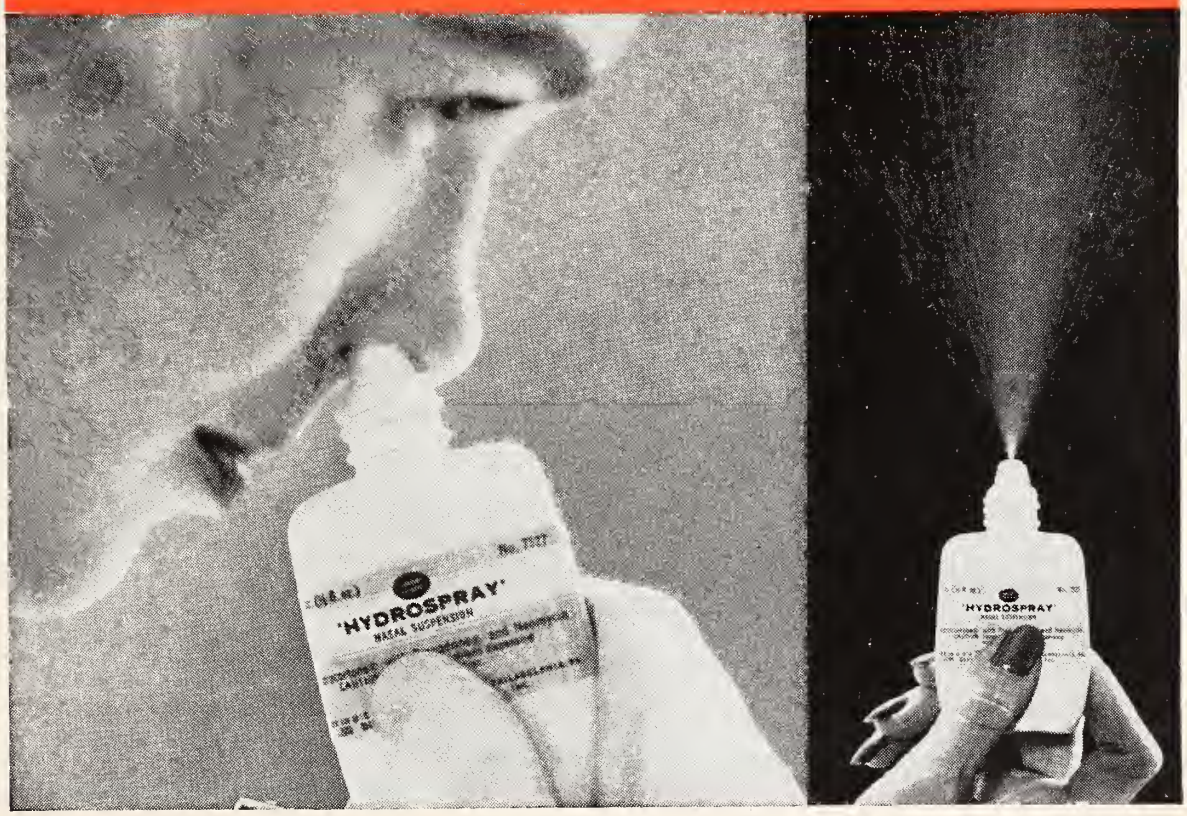
Dearborn-Ohio County Medical Society officers elected to serve during 1956 are Dr. L.

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M. Baker, Aurora, president; Dr. C. W. Olcott, Aurora, vice-president; Dr. J. M. Pfeifer, Lawrenceburg, treasurer; Dr. F. D. Houston, Lawrenceburg, secretary; Dr. J. K. Jackson, Aurora, and Dr. Gordon Fessler, Rising Sun, delegates; and Dr. George Vail, Lawrenceburg, alternate delegate. Meetings of the society are held the third Thursday of each month.

A report by the field secretary of Indiana State Medical Association and election of officers for 1956 followed a luncheon meeting of eight members of **Decatur County Medical Society** December 20 in the Decatur County Memorial Hospital in Greensburg.

Dr. W. R. Shaffer, Greensburg, was named president; Dr. Louis Walker, Greensburg, vice-president; Dr. Robert A. Porter, Westport, secretary-treasurer; Dr. Shaffer, delegate, and Dr. James C. Miller, Greensburg, alternate delegate.

R. J. Amick discussed current legislation and action taken at the December meeting of A.M.A. in Boston.

Delaware-Blackford County Medical Society officers elected to serve in 1956 are: Dr. Wendell Covalt, Muncie, president; Dr. Anson G. Hurley, Muncie, president-elect; Dr. Francis E. Stout, Muncie, secretary; Dr. Phillip Ball, Muncie, treasurer; Drs. R. M. Butterfield and Dr. Tom Brown, Muncie, and Dr. William Douglas, Montpelier, delegates. Alternate delegates are Drs. G. E. McCoy and Thomas Botkin, Muncie, and Dr. Paul E. Burns, Montpelier.

Fourteen members of the **Dubois County Medical Society** met December 8 in the Huntingburg Country Club for their annual dinner meeting. Eight members of the Auxiliary joined them for dinner and held a separate meeting later. A musical program was played during the dinner hour.

Dr. J. H. Barrow, Dale, was elected president for 1956; Dr. A. L. Wagner, Jasper, president-elect; and Dr. E. J. Ploetner, Jasper, secretary-treasurer.

Robert J. Amick, ISMA field secretary, made a report of the AMA meeting in Boston, discussed services available from the headquarters office, and joined in a general discussion of current trends of interest to the profession.

Approximately 50 members of **Elkhart County Medical Society** attended the January 5 dinner meeting in the Hotel Elkhart.

Dr. David W. Cugall, Northwestern University, Chicago, was the guest speaker. He presented a paper on "Clinical Application of Pulmonary Function Tests."

At the business session a delegate's report on the 1955 annual convention of Indiana State Medical Association was presented; several local problems were discussed; and Kenneth W. Bush, field secretary, reported on important pending legislation in Congress.

Officers for the society for 1956 are: Dr. William M. Stubbins, president; Dr. E. G. Koehler, vice-president; Dr. Page E. Spray, secretary; Drs. S. T. Miller and Burton E. Kintner, delegates. All are Elkhart physicians.

Election of officers for 1956, fixing of dues, and several matters of routine and special business comprised the program of the **Floyd County Medical Society** December 9 when 27 members attended a dinner meeting in the New Albany Country Club.

Dr. Frederick K. Allen, New Albany, was reelected president; Dr. Kenneth H. Brown, New Albany, is vice-president; and Dr. Daniel H. Cannon, New Albany, was re-elected secretary-treasurer. Delegate to state convention is Dr. John M. Paris, New Albany; and alternate, Dr. Herbert P. Sloan, New Albany. The board of censors is composed of Drs. W. F. Edwards, James W. Baxter, and Parvin M. Davis.

Members of **Fountain-Warren County Medical Society** held a dinner meeting January 5 in the I and I Steak House near Danville, Illinois. Nine members and one guest, Dr. Paul E. Fishkorn of the DuPont Construction Company, attended.

During the business meeting arrangements were made to purchase a motion picture projector for use in scientific study.

New officers of the society are: Dr. Tsutomu T. Suzuki, Covington, president; Dr. Carl A. Nelson, West Lebanon, vice-president; Dr. Lowell R. Stephens, Covington, secretary-treasurer; Drs. Lee J. Maris, Attica, and James W.



Huntington County Medical Society members are pictured at a fall meeting. In the upper left photograph are Drs. E. D. Plasterer; Theodore V. Beutler, Fort Wayne, guest speaker; Richard Wagner, Grover M. Nie, Howard H. Marks, Stanley M. Casey, all of Huntington. Upper right, Drs. H. S. Brubaker, R. G. Johnston, and J. B. Eviston, Huntington. Lower left, Drs. W. A. Clunie and Thomas James, Jr., Huntington, and Haldon Woods, Markle. Lower right, Drs. Wallace S. Grayston and Floyd B. Mitman, Huntington.

Crain, Williamsport, delegates; and Drs. Stephens and Nelson, alternate delegates.

At an evening meeting of **Greene County Medical Society** on December 16, James L. Tolin, Blue Cross representative, discussed a number of insurance problems with the 13 members present. The meeting was held in Freeman Greene County Hospital in Linton.

Election of officers was held and a number of hospital matters discussed.

The following officers have been elected to serve **Hamilton County Medical Society** during 1956: Dr. Harold W. Shonk, Noblesville, president; Dr. Alton Ridgway, Lapel, vice-president; and Dr. Joe R. Lloyd, Noblesville, secretary-treasurer.

Hendricks County Medical Society members held their December meeting in the O. K. Restaurant in Danville with 13 present for the luncheon and business meeting.

At the annual election of officers Dr. Kermit Hibner, Danville, was named president for 1956; Dr. Lloyd E. Foltz, Brownsburg, vice-president; Dr. James E. Southard, Danville, secretary-treasurer; Dr. O. T. Scamahorn, Pittsboro, delegate; and Dr. Lloyd Terry, Danville, alternate.

R. J. Amick, field secretary for Indiana State Medical Association, gave a report on the recent AMA meeting.

Thirty-five members and five guests of **Howard County Medical Society** attended a dinner meeting in the Frances Hotel in Kokomo on January 3. Following the dinner a movie on "The Use of Adrenosem" was shown. The next meeting was scheduled for February 8 at the same time and place.

Jefferson-Switzerland County Medical Society members recently elected new officers for 1956. Heading the society will be Dr. Ott B. McAtee, Madison, president; Dr. W. K. Haney, Madison, vice-president; Dr. W. E. Childs, Madison, secretary-treasurer; Dr. M. O. Alcorn, Madison, delegate; and Dr. Francis Prenatt, Madison, alternate delegate.

Johnson County Medical Society officers for 1956 are Dr. Helen B. Barnes, Greenwood, president; Dr. Arthur W. Records, Franklin, president-elect; Dr. Robert H. K. Foster, Franklin, secretary-treasurer; Dr. William D. Province, Franklin, delegate to state convention; and Dr. Joseph F. Ferrara, Franklin, alternate delegate.

Twenty-five members of **Knox County Medical Society** attended the dinner meeting and



Marshall County physicians pictured here are: upper left, Drs. Otis R. Bowen, Bremen; M. O. Klingler, Plymouth; Rex K. Pomeroy, Plymouth; D. Stanley Houser, Lakeville (St. Joseph county). Upper right shows Drs. Robert G. Reed, Plymouth; Warren E. Coggeshall, Indianapolis guest speaker; James S. Robertson, Plymouth.

Below, left, Drs. A. A. Thompson, Tyner; Marshall E. Stine, Bremen; Milan D. Baker, Culver; and right, Drs. James D. Knbley, Harry Danielson and L. W. Vore, all of Plymouth; and T. H. Nichols, Knox (Starke County).

annual election of officers in the Grand Hotel, Vincennes, on December 20.

Officers for 1956 are Dr. William C. von der Lieth, Vincennes, president; Dr. Robert Byrne, Bicknell, vice-president; and Dr. Norbert Welch, Vincennes, secretary-treasurer.

The 1956 officers of **Kosciusko County Medical Society** are Dr. Ryland Roesch, Warsaw, president; Dr. Wymond B. Wilson, Mentone, vice-president; Dr. Walter Hurt, North Webster, secretary-treasurer; and Dr. E. W. Thomas, Warsaw, delegate to the Indiana State Medical Association.

Dr. A. A. Wade, Howe, was recently elected president of the **LaGrange County Medical Society** for 1956. Serving with him are Dr. Charles D. Benedict, LaGrange, vice-president; and Dr. Harley F. Flannigan, LaGrange, secretary-treasurer.

Officers for 1956 were installed at a dinner meeting of the **Lake County Medical Society** January 11 in Gary. Dr. Robert G. Husted, Hammond, president; Dr. Franklin F. Premuda, Hammond, president-elect; and Dr. John Reed, Hobart, board chairman, assumed their offices.

Lawrence County Medical Society members met in Dunn Memorial Hospital, Bedford, January 4, for a noon luncheon meeting with 20 physicians attending.

A film on "Local Anesthesia" was shown. Members voted to express opposition as a society to any further expansion of the Social Security Act at present and to inform both U. S. Senators of their opposition to H.R. 7225. They went on record as favoring the Reed-Keogh bill.

The 1956 officers of the society are Dr. J. B. Wohlfeld, Bedford, president; Dr. W. H. Robinson, Mitchell, vice-president; and Dr. Richard D. Hawkins, Bedford, secretary-treasurer. Dr. L. E. Benham, Bedford, is delegate, and Dr. Hawkins, alternate.

Dr. Glenn Irwin, Indianapolis, was guest speaker at the December 19 meeting of the **Madison County Medical Society.** His subject was "Recent Trends in Endocrine Problems." Thirty-nine members attended the dinner meeting in Anderson Country Club.

The following officers for 1956 were elected: Dr. W. E. Fischer, Anderson, president; Dr. H. D. Webb, Anderson, vice-president; and Dr. M. P. Benoit, Anderson, secretary-treasurer. Drs. P. T. Lamey and Gordon Wilder were named delegates, and Drs. S. W. Ellis and J. L. Larmore, alternate delegates.

Both the December 7 and January 4 meetings of the **Marshall County Medical Society** were held in the Warana Restaurant in Plymouth where business meetings were held following 12:30 luncheons. Twelve members attended the December meeting and 13 the January meeting.

Dr. J. S. Robertson, Plymouth, was elected president for 1956; Dr. Harry E. Danielson,

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Plymouth, vice-president; and Dr. James F. Rimel, Plymouth, secretary-treasurer. The delegate to ISMA is Dr. Alfred A. Thompson, Tyner; and Dr. M. O. Klingler, Plymouth, is alternate.

At the January meeting Dr. Robert G. Reed was appointed program chairman for the year. During a lengthy business meeting several subjects of both local and national interest were discussed. K. W. Bush, field secretary, outlined ISMA services available to members and reported on several bills in Congress which should be of vital interest to the medical profession. Dr. James D. Kubley is chairman of the 1956 legislative committee of the society.

The **Noble County Medical Society** held its combined annual meeting for election of officers and Christmas party in the Kendallville Country Club at noon on December 15. Seventeen physicians were present and Kenneth W. Bush, field secretary, was a guest.

Dr. E. D. Mattmiller, Avilla, was named president; Dr. Paul Webster, Ligonier, vice-president; Dr. Frank W. Messer, reelected secretary-treasurer; Dr. J. R. Nash, Albion, delegate; and Drs. H. O. Williams and I. H. Lawson, Kendallville, alternates.

During the remainder of the business session members heard a report on headquarters activities from Mr. Bush; voiced opposition to further extension of compulsory social security; appointed a committee to set up an average fee schedule; and heard a brief report by Dr. I. H. Lawson, retiring president, on activities and accomplishments of the society during 1955.

Twelve members of **Parke-Vermillion County Medical Society** met for dinner and their annual election December 21 in the Vermillion County Hospital at Clinton.

Dr. Dorothy B. Lauer, Dana, was named president for 1956; Dr. Paul Pickett, Clinton, secretary-treasurer; Drs. Milton Herzberg, Clinton, and B. M. Merrell, Rockville, delegates; and Drs. Pickett, Clinton, and Casper Harstad, Rockville, alternate delegates.

Approval was given to a patch testing program by the county nurse. Robert J. Amick, field secretary, reported on action of the AMA House of Delegates at the December meeting, and discussed several problems of mutual interest to all physicians.

More than 100 members of **St. Joseph County Medical Society** heard Dr. Marion W. Hillman, president, outline benefits of a combined city and county health service to replace the separate health offices of South Bend, Mishawaka and St. Joseph County. The meeting was held December 13 in the Northern Indiana Children's Hospital. Members adopted a resolution directed to the county commissioners in which they asked creation of such a health department.

Rush County Medical Society members recently elected Dr. Donald I. Dean, Rushville, to serve as president during 1956. Other new officers are Dr. W. H. Nutter, Rushville, vice-president; Dr. Harry G. McKee, Rushville, secretary-treasurer; Dr. Frank H. Green, Rushville, delegate to I. S. M. A., and Dr. Robert B. Johnson, Rushville, alternate delegate.

Dr. James H. Crowder, recently elected president of **Sullivan County Medical Society**, entertained the society at a dinner meeting at the Apple Club in Terre Haute on January 5. Fifteen members were present, representing the medical society and the county hospital staff.

A general business meeting was held followed by a staff meeting. A report of current activities was made by R. J. Amick, field secretary.

Dr. J. S. Brown was reelected to serve as secretary-treasurer for 1956.

Dr. Raymond B. DuBois, Lafayette, was elected president of the **Tippecanoe County Medical Society** at a dinner meeting December 13 at The Trails, Lafayette. Other 1956 officers are Dr. Frank W. Peyton, Lafayette, vice-president; Dr. Robert C. McAdams, Lafayette, secretary; Dr. Forrest J. Babb, Stockwell, treasurer; Dr. Dubois and Dr. W. W. Washburn, Lafayette, delegates; and Drs. K. O. Neumann and M. J. Eaton, Lafayette, alternates.

More than 130 members of **Vanderburgh County Medical Society** attended the December 13 dinner meeting in the Hotel McCurdy, Evansville.

At the annual election of officers after dinner, Dr. W. Russel Springstun, Evansville, was

named president-elect and will assume the presidency January 1, 1957. Other officers are: Dr. W. Lawrence Daves, Evansville, president; Dr. John H. Combs, Evansville, treasurer; Drs. James Crawford and William Fisher, board of directors; Dr. J. D. McDonald, board of censors; Dr. Dallas Fickas and Dr. Henry Rusche, delegates to I. S. M. A.; and Drs. P. J. V. Corcoran and Dan Hare, alternates.

A panel presentation on insurance coverage followed. Dr. Dan Tweedall introduced the program, Dr. W. L. Daves served as moderator and the following members were panelists: Drs. John Alexander, Eugene Austin, Ralph Zwickel, Charles Schneider, Paul Steele, John Sterne, P. J. V. Corcoran, C. A. Hartley and Arthur Griep.

A full report of actions of the American Medical Association at the midwinter meeting in Boston was given by James A. Waggener, executive secretary of Indiana State Medical Association, who also participated in the panel discussion and presented a report of state association activities.

Dr. Howard Mitchell, director of the Division of Maternal and Child Health, Indiana State Board of Health, and Dr. Richard Griffith of the Lilly Research Clinic, Indianapolis, were guest speakers at the December 13 meeting of **Vigo County Medical Society** in the St. Anthony Hospital, Terre Haute. Dr. Mitchell discussed public health problems and Dr. Griffith presented a paper, illustrated by a colored film on "Antibiotic Therapy".

At the election of officers for 1956 during the business session, Dr. William L. Strecker, Terre Haute, was named president; Dr. Henry W. Bopp, Jr., Terre Haute, vice-president; and Dr. H. T. Goodman, reelected secretary-treasurer. Other officers reelected were Dr. A. W. Cavins, to the board of trustees for three years; Dr. Noel McBride, to the board of censors for three years; Dr. Cavins and Dr. Goodman as delegate and alternate delegate to the Indiana State Medical Association for two years. Dr. E. O. Nay and Dr. Wm. C. Kunkler are holdover delegate and alternate.

Robert J. Amick, I. S. M. A. field representative, was a guest.

Officers elected to serve **Wells County Medical Society** during 1956 are: Dr. Jack L. Eisaman, president; Dr. Richard P. Yoder, vice-president; Dr. Robert G. Cook, secretary-treasurer; Dr. Truman E. Caylor, delegate to I. S. M. A.; and Dr. Eisaman, alternate delegate. All are Bluffton physicians.

Whitley County Medical Society officers for 1956 were elected at a dinner meeting in the Whitley County Hospital, Columbia City, December 13.

Dr. T. G. Hamilton, Columbia City, was named president; Dr. Ernest A. Hershey, Churubusco, was named vice-president; Dr. Warren L. Niccum, Columbia City, secretary-treasurer; Dr. L. J. Minick, Churubusco, delegate; and Dr. T. G. Hamilton, Columbia City, alternate.

A lengthy discussion of immunization programs and several other local subjects followed. Kenneth W. Bush, I. S. M. A. field secretary, spoke concerning social security legislation, tape recordings available from I. S. M. A. and other headquarters services. Dr. James R. Roth, Wolf Lake, was also a guest.



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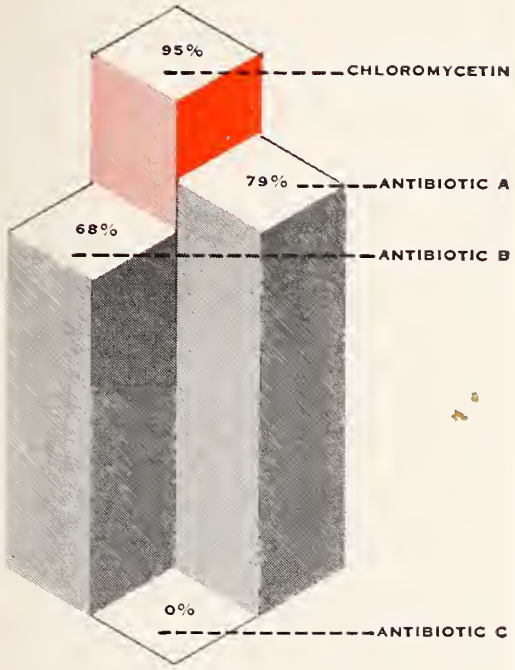
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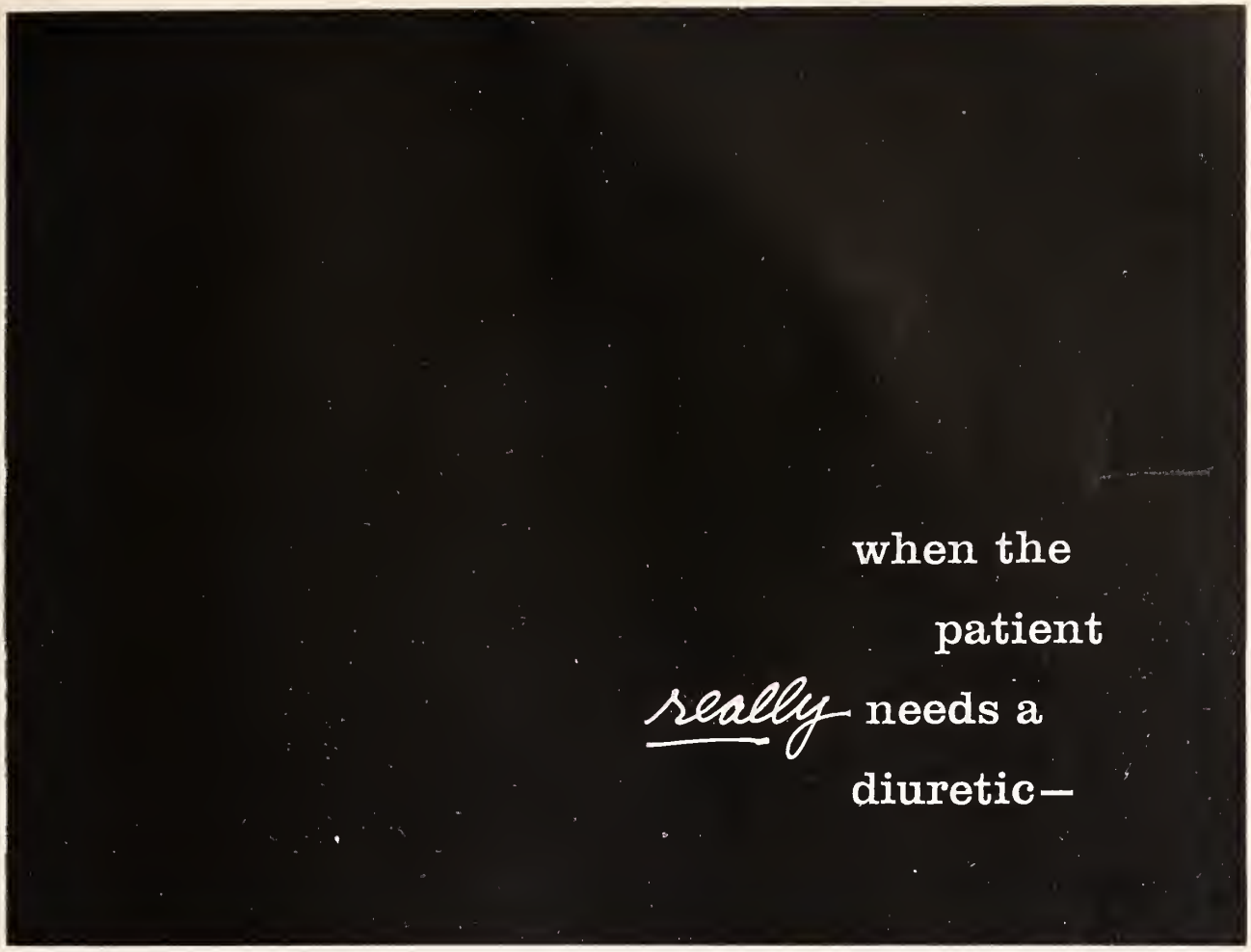
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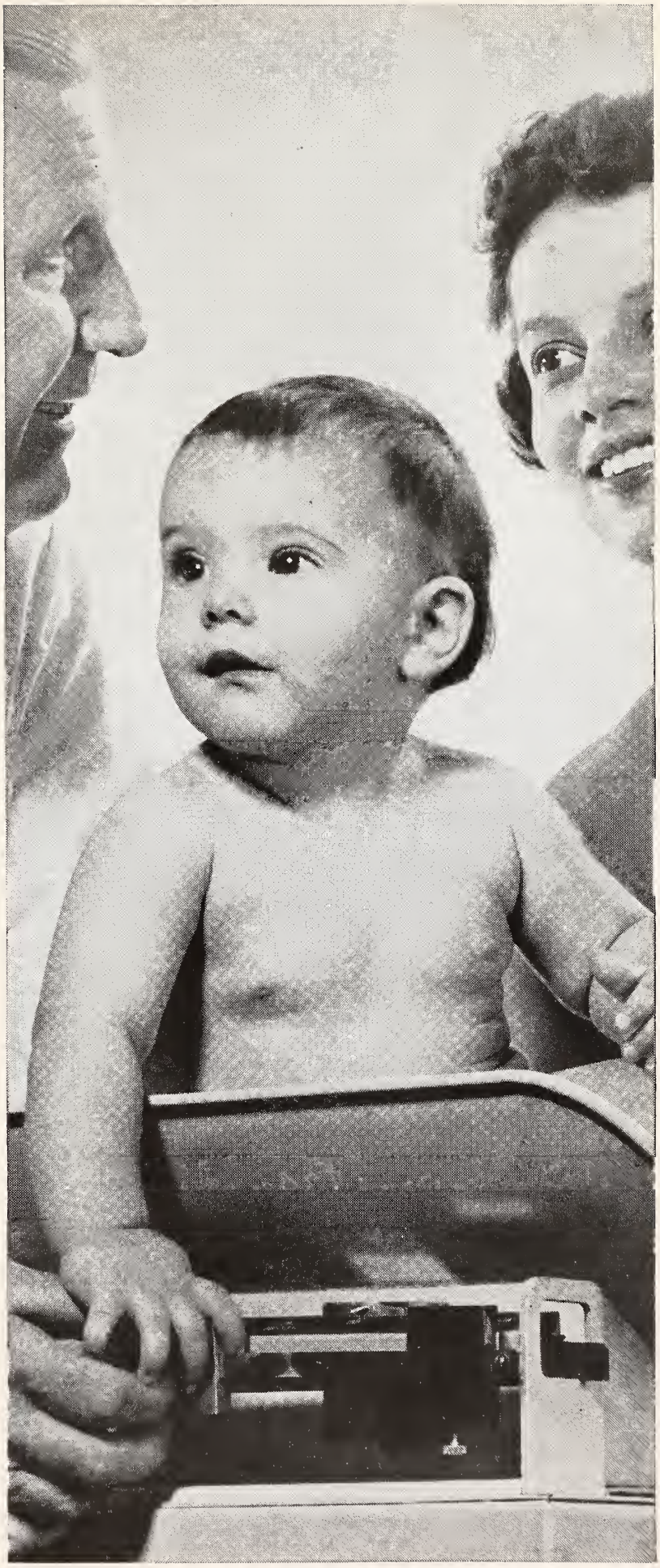
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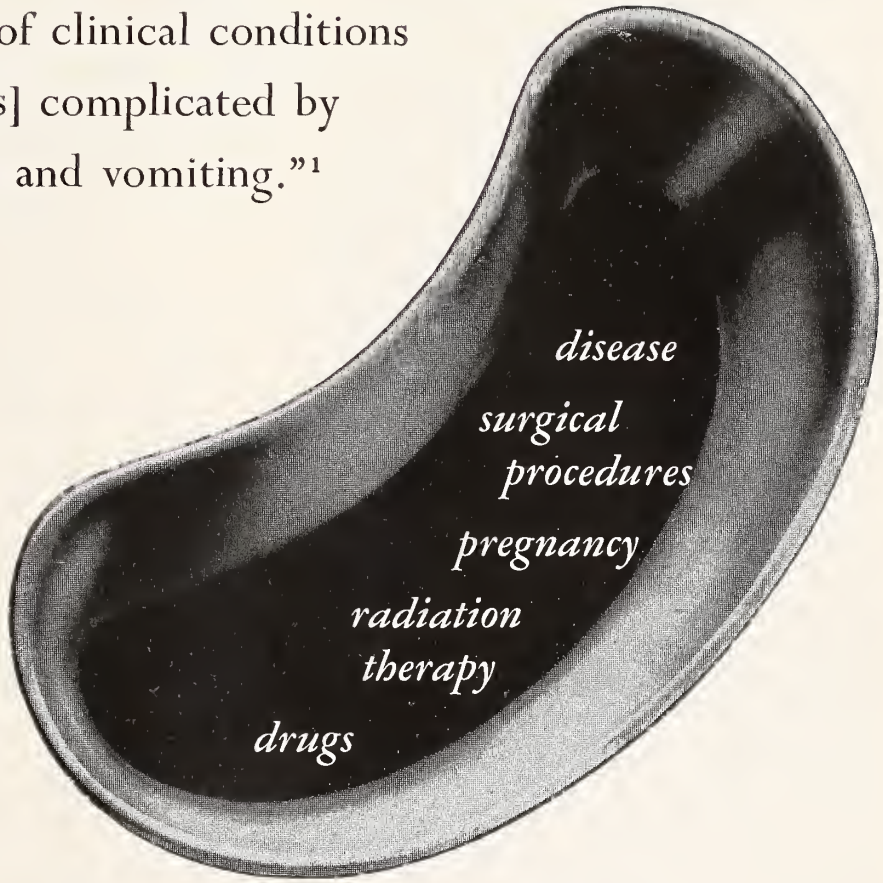
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1. Moyer, J.H., et al.: Arch. Int. Med. 95:202 (Feb.) 1955.

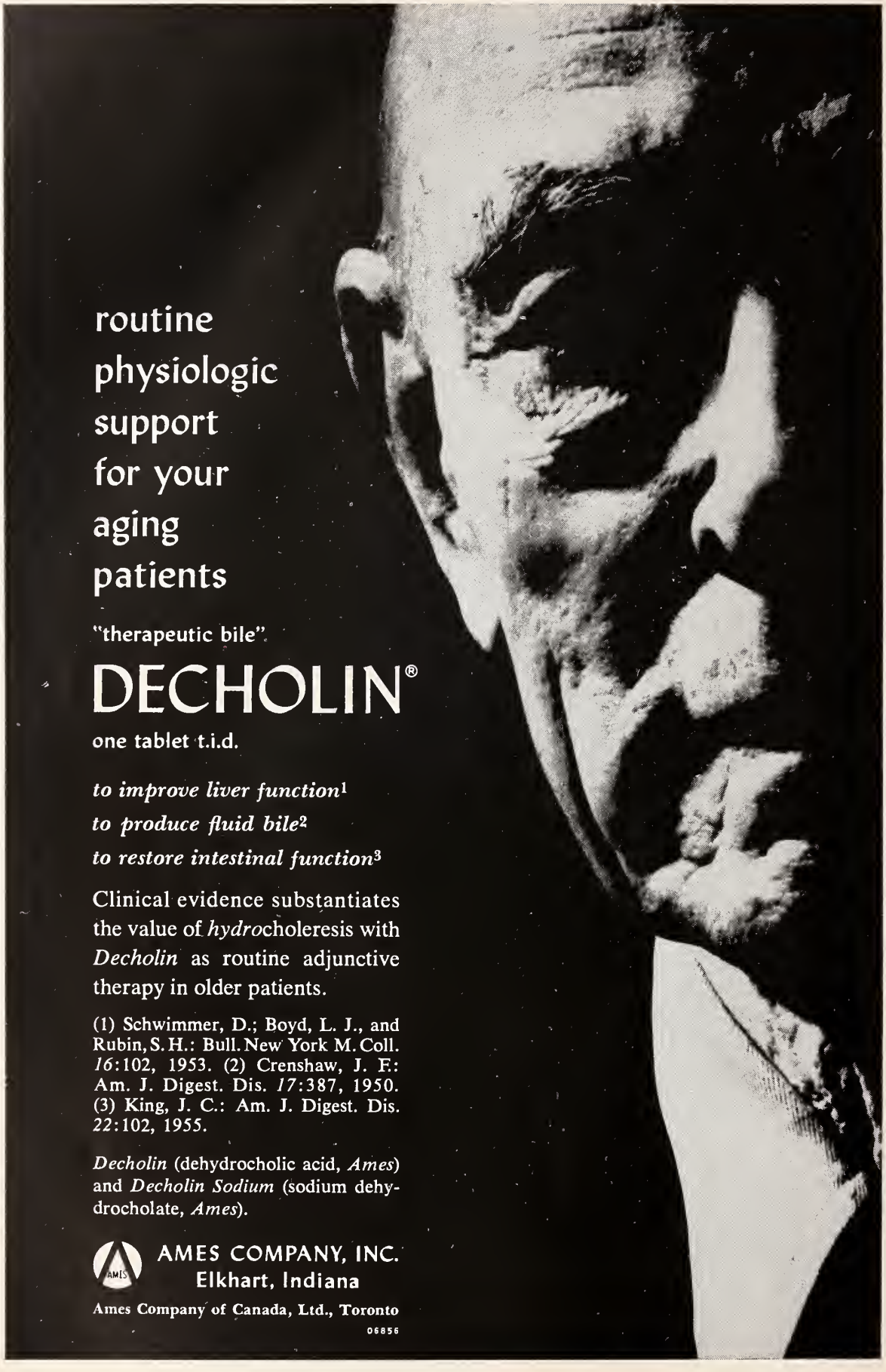
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(1) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953. (2) Crenshaw, J. F.: Am. J. Digest. Dis. *17*:387, 1950. (3) King, J. C.: Am. J. Digest. Dis. *22*:102, 1955.
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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C.—All too frequently overlooked in Congressional activity on health and related bills each year are the little-publicized but highly important appropriations measures—without which no program of the federal government could move forward. The appropriations hearings in the House (where all money bills must originate) rarely get headlines; they are conducted behind closed doors. Weeks and some times months later, the hearings are published, but by then the bill supplying money for an agency has been reported to the House.

It's only when the measure gets to the Senate that private groups and individuals are heard—by then in open sessions. Closed House sessions are not new. That is the way it has been done ever since Congress set up a separate committee on appropriations back in 1865.

The importance of appropriations in running the federal government was clearly illustrated when the President submitted to Congress his 1,272-page budget message in which he sought $65.9 billion for all federal programs for the fiscal year beginning July 1.

While there was no overall total of projected spending by all the agencies in the health field, the budget requests for the Department of Health, Education, and Welfare showed a sharply upward trend. And if certain new legislation is voted on this session—like the projected 5-year program of construction grants for medical schools and private laboratory facilities—the total figure for subsequent years is likely to be even higher.

On the medical school-laboratory construction bill, the President asked Congress for $40 million for the first year (estimated cost over five years is $250 million). Construction grants, which would have to be matched on a 50-50 basis, would be available for private medical schools as well as non-federal laboratories conducting research into a wide range of crippling diseases.

The budget message also calls for another $30 million in outright grants, to the states to help them in financing poliomyelitis vaccination programs, the same amount appropriated by Congress last session. The administration in a separate request asked for extension of the polio law, from February 15, 1956 to June 30, 1957, and both the House and Senate with only brief debate voted the 17-month extension. Since only half of last year's $30 million was spent up to the February 15 expiration date of the original act, there was no rush for Congress to act on the new account.

Other new spending asked by the administration, contingent, of course, on enabling legislation, includes $10 million for initial capitalization of mortgage loan guarantees for health facilities; $5 million for graduate and practical nurse and professional health personnel training, $3 million for water pollution grants; $1.5 million for mental health expansion programs; and $1 million for sickness and disability surveys in the United States.

If Congress approves the requests, virtually all segments of the Department of HEW will have more money to spend than in this fiscal year. None would benefit more, however, than the medical research arm of government, the National Institutes of Health. The total sought for the seven institutes is 28% more than estimated spending this year. Here are some examples: National Cancer Institute, $32,437,000,

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up 29%; National Heart Institute, $22,106,000, up 17%, and the National Institute of Allergy and Infectious Diseases (formerly the National Microbiological Institute), $9,799,000, a 26% increase.

The President requested $130 million for the Hill-Burton hospital-clinic construction program which will be 10 years old this August. In this connection Congress has been asked to extend the act for two years beyond next year, and action is expected this session.

NOTES

After a study of possibilities in the *peaceful uses of atomic energy*, a panel has recommended among other things, that the U. S. encourage states and private organizations to take full advantages of the opportunities offered by radioactive material for medical research and treatment.

It now appears that an improved and more uniform program of *medical care for service families* will be adopted this session—possibly before this is published. One feature: A $25 deductible charge in civilian hospitals, but with the government paying the full insurance premium, and a mandatory subsistence charge in military hospitals.

Making slower progress is the plan—under consideration for more than a year—for a *health insurance program for U. S. civilian workers.* Here the government would pay about half the cost.

Several committees are urging stricter penalties and other changes *to bring the illicit narcotic traffic under better control;* so far no suggestion of more controls over the medical profession in the handling of narcotics.

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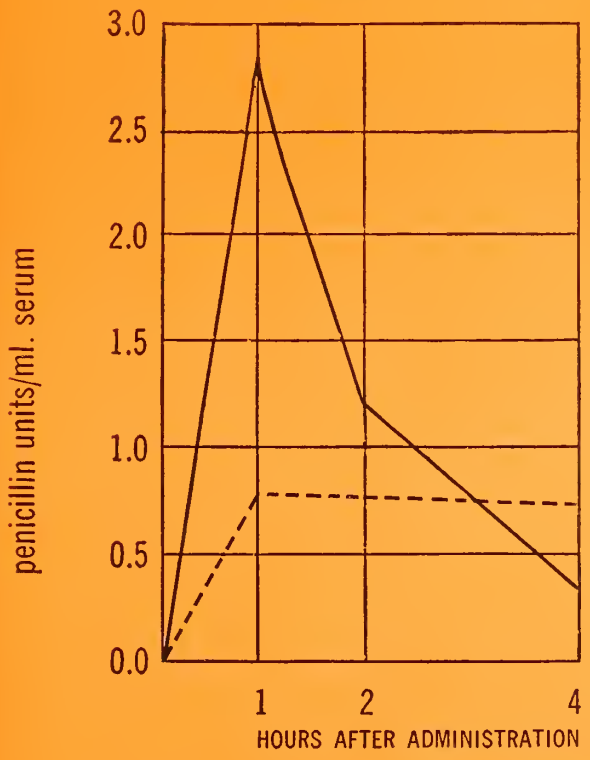
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1. Wright, W.W.: Personal communication.
2. Price, A.H.: Personal communication.

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The Fourth Estate Looks At Medicine

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THE HEALTHY CHANGE

In his present memoirs, Mr. Truman writes in connection with a Federal health plan:

"On November 19, 1945, I sent Congress a message recommending national compulsory health insurance through payroll and other deductions. Under the plan, all citizens would be able to get medical and hospital service regardless of ability to pay."

Mr. Truman notes his plan was defeated. But Mr. Truman is still of the view that his proposal is the only one that will provide proper medical care for the nation. "This opposition has only delayed and cannot stop the adoption of an indispensable Federal health insurance plan." The people who feared socialized medicine, by whatever name Mr. Truman called it, were called by Mr. Truman "reactionary and selfish people."

The other day Mr. Eisenhower submitted his ideas on the nation's state of health. This message is different from Mr. Truman's, and it is also different from Mr. Eisenhower's of last year and the year before. Then, the President, who recognized dangers in Federal medical control Mr. Truman couldn't or wouldn't see, proposed that the extent of Federal insurance—and thus control—be limited to a reinsurance program for the many voluntary health prepayment plans. The reasoning was that some sort of Federal insurance would allow the private companies to widen their coverage and their benefits. More people would be insured against ill health, accidents, higher hospital and medical costs than ever before, and they would be insured at lower rates.

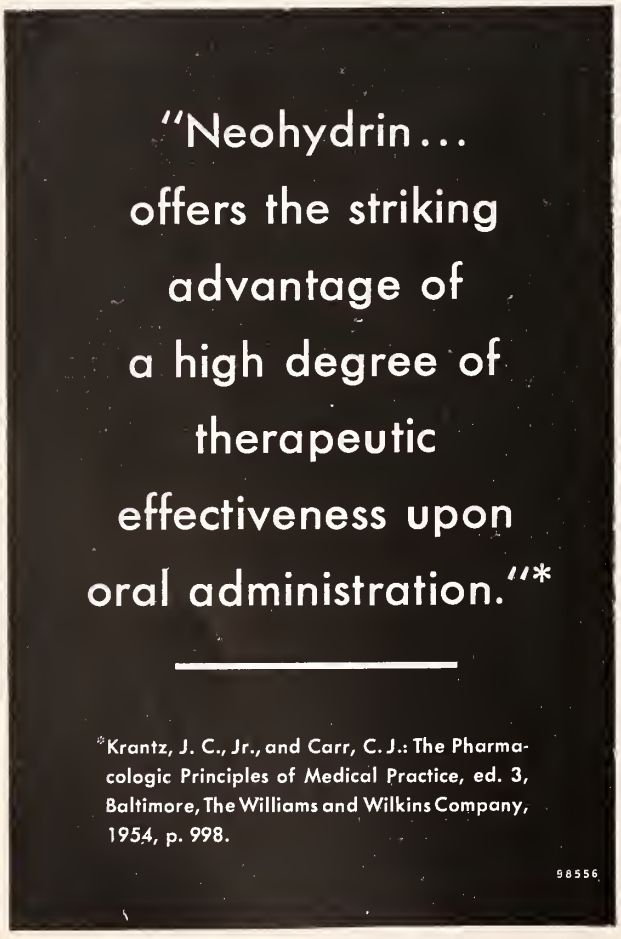
In his message last week, Mr. Eisenhower again calls attention to the need for expanded coverage for "older persons, those living in rural areas, the self-employed" and those working in small companies which cannot be enrolled in the ordinary group plans covering large organizations. In addition, some provisions must be made "against the cost of long-term or other especially expensive illness."

"The need," he says, can best be met by "building on what many of our people have already provided for themselves—the voluntary health prepayment plans." Mr. Eisenhower notes that since he first proposed Federal insurance, the private organizations have developed new types of policies which extended coverage to people formerly unable to qualify. The private companies he believes, are well on the way to provide the sort of medical insurance the nation needs.

To encourage expansion of health insurance, the President announced that the Administration is studying legislation to allow the many different prepayment groups to pool their risks. The President hopes that practical and useful methods of spreading health care and ending worry about the bills will result without any federal aid and control over hospitals and doctors.

Unquestionably the plan is a healthy change from the request last year for $100 million for Federal reinsurance. Unquestionably it indicates that the private companies can provide the care.

And unquestionably there will be some opposition to this approach. It will come from those who think, as Mr. Truman still thinks, that the only answer to health is to let the Federal government run the hospitals and to turn the family doctor into a Federal agent.—*Review and Outlook in Wall Street Journal.*

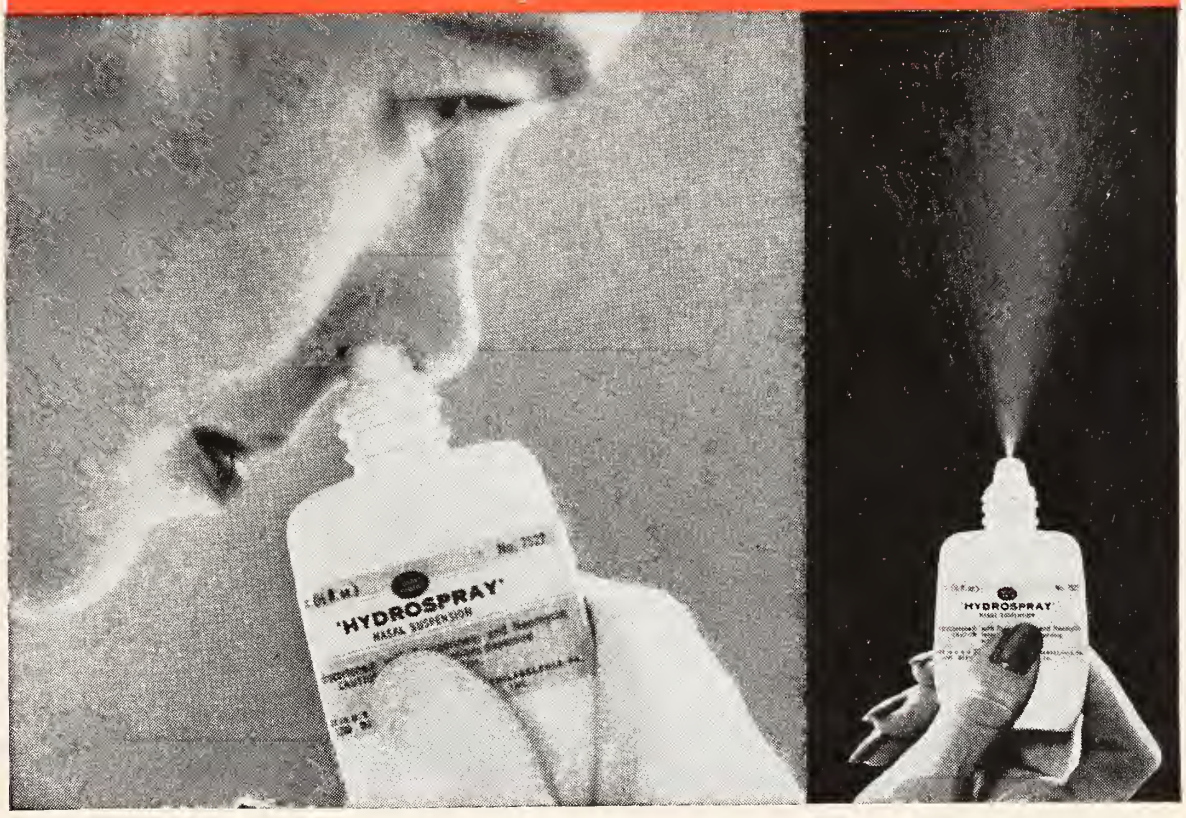


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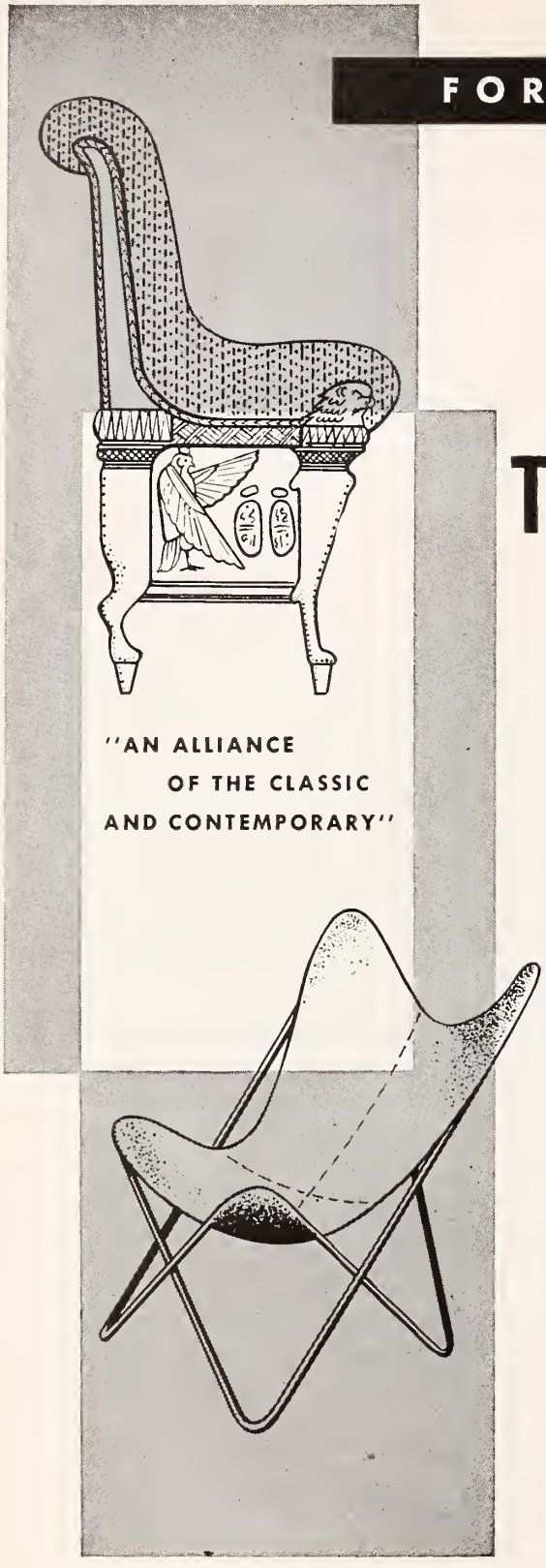
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TWENTY INDIANA COMMUNITIES contacted the Physicians Placement Service of the Indiana State Medical Association during December and January. All were seeking physicians; several were repeated requests for help in securing medical services for their towns and cities. Inquiries came from communities ranging in size from a population of 450 to an industrial city of 115,000.

Information concerning openings for physicians in Indiana may be had in detail by contacting the person designated in each case.

Current listings include:

NEW HAVEN—Allen County; population 1,900. Located close to Fort Wayne. Dr. Roger C. Smith, 1610 Pemberton Drive, Fort Wayne, Indiana, is looking for a general practitioner for a well-established office in New Haven, Indiana. Contact Dr. Smith.

WOODBURN—Allen County; population 560. Located 16 miles east of Fort Wayne on Route 101. Prosperous farming area of Allen County. A community health center is being planned. For further information contact Mr. Donald G. Gundy, Woodburn.

ZIONSVILLE—Boone County; population 1,633 with 1,500 outside city limits. Fifteen miles from Indianapolis and Lebanon where hospital facilities are available. Two M.D.'s for 3,500 population—one 65 years of age and wants semi-retirement. Contact L. S. Bailey, M.D., Zionsville, Indiana.

ENGLISH—Crawford County; population 750; county seat town. Contact Mrs. William L. Criswell, English.

MUNCIE—Delaware County; population. 49,720. Office and equipment of Dr. J. H. Williams available. Located at 306 East Jack-



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son Street. Excellent hospital facilities—open staff. Dr. Williams is retiring. Contact Mrs. Robert J. Wadsworth, 907 University Avenue, Muncie, Indiana.

HOLLAND—Dubois County; population 507. Community willing to build office and home if a good doctor is available. Medium-sized furniture plant, Holland Custard and Ice Cream, Inc., and a large printing plant are located in town. Nearest hospital is 8 miles away in Huntingburg. Contact Mr. B. J. Caldemeyer, Holland Custard and Ice Cream, Inc., Holland, Indiana, for details.

ELKHART—Elkhart County; population 35,650. Opening for eye, ear, nose and throat specialist. Contact Dr. Robert S. Bolin, 1853 East Beardsley Avenue, Elkhart, Indiana.

PENNVILLE—Jay County; population 625. Nearest doctor 10 miles. Hospital facilities in Portland, 12 miles from Pennville. Contact Mr. John A. Elliott, Pennville, Indiana.

EDWARDSPORT—Knox County; population 1,350. Large surrounding area without services of a physician. Office and residence available. 19 miles from Vincennes. Contact Mrs. W. F. Nelson, Edwardsport, Indiana.

SILVER LAKE—Kosciusko County; population abount 1,000. Population includes resort with many year round residents. Three other resorts within 6 mile radius. 12 miles from Warsaw where hospital facilities are available. New clinic just completed by local Lions Club. Residents of community are willing to give financial aid to right doctor. Contact Mr. Charles H. Raber, Silver Lake, Indiana.

LaCROSSE—LaPorte County; population 600, with a surrounding territory population of 3,000. Physician who has served community many years is retiring. Good opening and opportunity for enthusiastic doctor. Prosperous town and farming territory. Contact Edmund J. Bechler, president, Board of Trustees, LaCrosse, Indiana.

BUNKER HILL—Miami County; population 560. Dr. Lloyd L. Hill is being called into service. He has a young and rapidly growing practice, 15 minutes from hospital at Peru. Would like to have some young doctor take over for two years. Contact Lloyd L. Hill, M.D., Bunker Hill, Indiana.

MONROVIA—Morgan County; population 500. Prosperous rural community, 12 miles from Martinsville, and 22 miles from Indianapolis. Contact Mr. Roy Kenworthy, Monrovia, Indiana.

CROMWELL—Noble County; population 450 with large surrounding rural territory. Contact Oliver W. Griffith, P. O. Box 38, Cromwell, Indiana.

LIGONIER—Noble County; population 2,500. Dr. J. B. Schutt, who has practiced in Ligonier for more than 20 years, is leaving for Florida. Office and residence available. Contact Dr. J. B. Schutt, 404 South Cavin Street, Ligonier, Indiana.

GOSPORT—Owen County; population 822. 12 miles from Martinsville. No physician in town; closest one is 10 miles. Contact Malcolm E. Taylor, Gosport, Indiana.

ROACHDALE — Putnam County; population 735. No physician in town. Large surrounding farming community. Contact Mrs. A. F. Higgins, Roachdale, Indiana.

ROSEDALE—Parke County; population 750. 15 miles north of Terre Haute. Home and office available. Contact Mr. Bert L. Wheat, Rosedale, Indiana.

SOUTH BEND—St. Joseph County; population 115,911. Opening for young physician to share office. Practice may be purchased when doctor retires. Contact V. E. Harman, M.D., 302 Sherland Building, South Bend, Indiana.

SOUTH BEND—St. Joseph County; population 115,911. Healthwin Hospital has opening for staff physician at a county-owned tuberculosis hospital. Contact Edward W. Custer, M.D., 1111 West Darden Road, South Bend, Indiana.

BATTLE GROUND—Tippecanoe County; population of 600 with a surrounding population of 2,200. Located 8 miles from Lafayette. Contact Mr. C. F. Walters, Druggist, Battle Ground, Indiana.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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Paul A. Dosch, M.D., (general practice) (available November, 1956) 811 Vest Drive, Warrensburg, Missouri.

Donald H. Rames, M.D. (general practice) 14833 Fairfield Avenue, Detroit 38, Michigan.

James H. Tower, Jr., M.D. (general practice) (available July, 1956) 1615 Hall Place, No. 3, Indianapolis 2, Indiana.

Harry R. Hittner, M.D. (general practice) (available July, 1956) USAH Box 189, Fort Benning, Georgia.

James A. Fleming, M.D. (general practice) Riverside General Hospital, Arlington, California.

Edward W. Foster, M.D. (surgery, Ob.-Gyn. general practice) 147 West Main Street, Meriden, Connecticut.

Mary F. Lyon, M.D. (pediatrics) 809 S. Marshfield, Chicago 12, Illinois.

Albert F. Cunningham, M.D. (general surgery) U. S. Naval Hospital, Memphis, Tennessee.

Richard R. Horning, M.D. (internal medicine) (available July, 1956) 3428 Ewald Circle, Detroit 4, Michigan.

Edwin F. McNichols, M.D. (internal medicine) (available October, 1956) 1457 Cherry Road, Chicago, Illinois.

Norman R. Ordahl, M.D. (general surgery associate) 208 South Huntington Avenue, Boston 30, Massachusetts.

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George H. Crandall, M.D. (general practice, partner or associate) (available July, 1956) Hartl Manor, Marshfield, Wisconsin.

Jack Gilman, M.D. (general practice) (available July, 1956) 1860 North Prospect Avenue, Apt. 5A, Milwaukee 2, Wisconsin.

Paul J. Singer, M.D. (industrial medicine) U.S. N.A.D., Crane, Indiana.

Roy M. Smith, M.D. (general practice) (available August, 1956) 119 Gardner Avenue, Albany, Georgia.

Frank E. Boyd, M.D. (general practice with surgery) 605 Hamilton Street, Norristown, Pennsylvania.

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1. Deuel, H. J., Jr.: Newer Concepts of the Role of Fats and of the Essential Fatty Acids in the Diet, Food Res. *20*:81 (Jan.-Feb.) 1955.

2. Meng, H. C.: Preparation, Utilization, and Importance of Neutral Fat Emulsion in Intravenous Alimentation, in Najjar, V. A.: Fat Metabolism, Baltimore, The Johns Hopkins Press, 1954, pp. 69-92.

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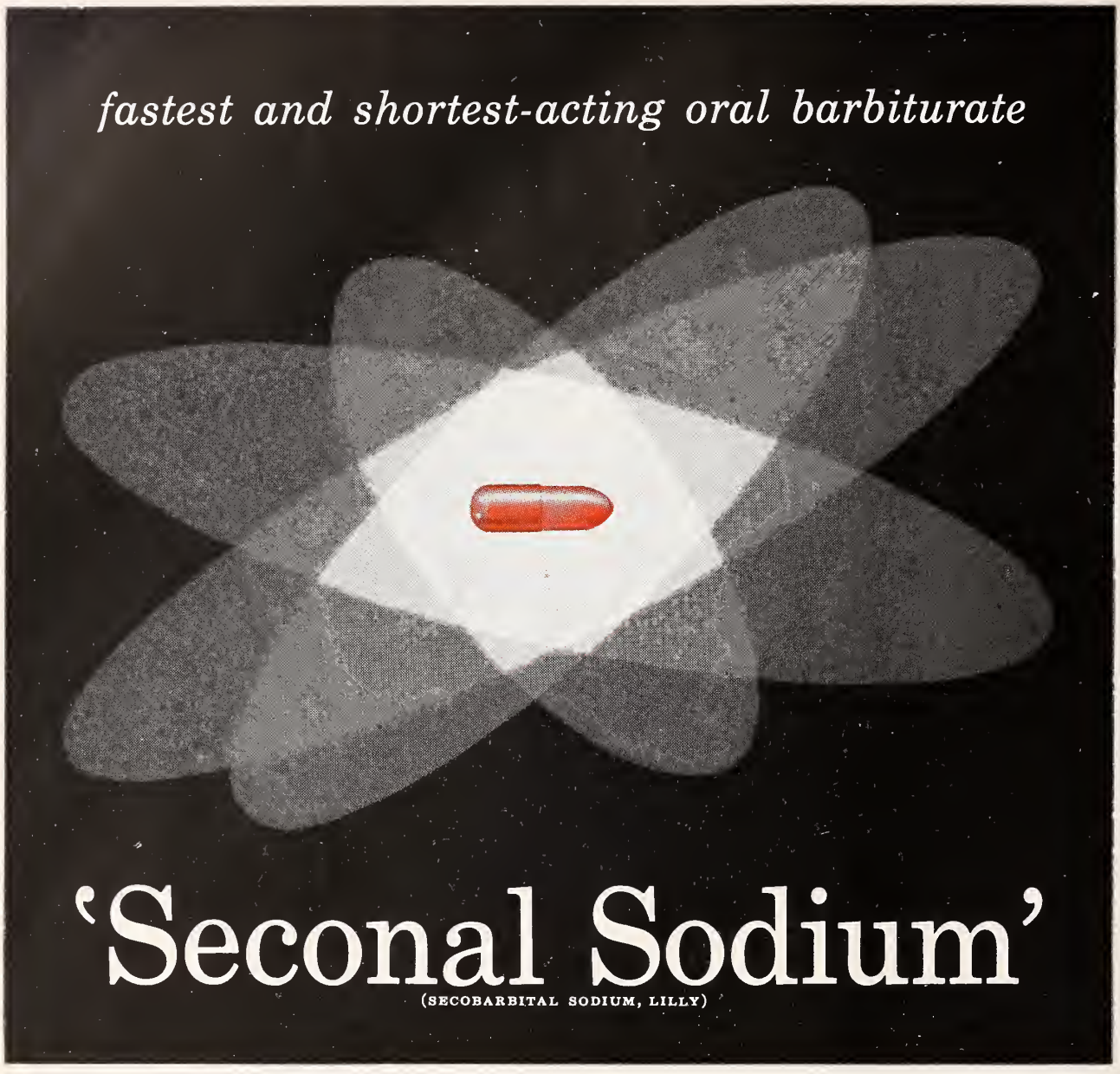
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Volume 49 — March 1956 — Number 3

Report of a Case of Myasthenia Gravis

FRANKLIN A. BRYAN, M.D.

Fort Wayne

THE ABILITY OF THE PATIENT with myasthenia gravis to tolerate large doses of cholinergic drugs is well known. It is the purpose of this note to report on one such patient whose very large requirements for such drugs were followed carefully from January 31, 1954 to January 30, 1955 inclusive, except for 6 days for which records are not available. During this period the patient received daily oral doses of both neostigmine and pyridostigmin* in the form of their bromide salts. The total consumption of neostigmine was 57,836 tablets (15 mg. each) and that of pyridostigmin, 53,468 tablets (60 mg. each). The daily dosage ranged from 75 to 256 tablets of neostigmine and 10 to 209 tablets of pyridostigmin. The average daily dose was 2,415 mg. neostigmine and 8,940 mg. pyridostigmin. On the day of largest intake of neostigmine (3,840 mg.), 2,520 mg. pyridostigmin was also administered. The largest daily dose of pyridostigmin (12,540 mg.) was accompanied by 3,045 mg. neostigmine. Thus, in one day this patient received over 15.5 *grams* of combined cholinergic drugs. We know of no other case in the literature where doses of this size were given for a comparable period.

REPORT OF A CASE

The patient is a married female in her late thirties. Coexisting with and complicating the picture of myasthenia are a history of mitral stenosis and a poorly defined but marked neuropsychiatric disorder. She was originally referred to me by a neuropsychiatrist. In early 1953 a prefrontal lobotomy was performed elsewhere, using the supra orbital method. This resulted in a temporary improvement in her myasthenia at which time she was taking about 25 tablets (375 mg.) neostigmine daily. Her neostigmine requirement increased to the point where she was taking about 150 tablets (2,250 mg.) daily in October

*Supplied as Mestinon® Bromide by Dr. M. J. Schiffrin of Hoffmann-La Roche, Inc.

1953. It was at this time that pyridostigmin was first given to her. She has had most of the classical signs of myasthenia gravis, including ptosis, dysphasia, dysphagia, diplopia and all of the extra ocular weakness, including difficulty in opening and closing the lids. She occasionally requires the use of a neck brace. There is extreme weakness of the tongue, jaw and the upper and lower extremities. She has suffered frequent falls and is often unable to arise without assistance.

Attempts have been made to support the patient on neostigmine or pyridostigmin alone but these have been without success and the best results were usually observed when approximately equal numbers of tablets of both drugs were used concurrently. In spite of the large oral doses of these drugs the patient frequently requires parenteral administration of 1 to 2 mg. neostigmine.

Hemograms were normal and unchanged until August, 1954. During this month she was placed on chlorpromazine, following which an anemia and leukopena were observed. Chlorpromazine was discontinued and the hemogram remained basically the same with the exception that the leukopenia was restored to normal. Unfortunately, she cannot tolerate any iron preparations. The patient had a miscarriage with considerable loss of blood in December 1954, following which the hemograms returned to normal values. Since then, chlorpromazine has again been given without further evidence of leukopenia.

On January 8 and 10, 1955 determinations of blood bromide were made in view of the considerable quantities of cholinergic bromide salts that were being used. During the 24 hours immediately preceding the first test, the patient took 2,280 mg. neostigmine and 9,840 mg. pyridostigmin. The blood bromide was 61 mg. %. The second test was made after the patient took 2,565 mg. neostigmine and 10,620 mg. pyridostigmin during a 24 hour period. The blood bromide was 68 mg. %. A third analysis for bromine was made on April 2, 1955 at which time the blood bromide was 48 mg. %.

COMMENT

J. E. Tether, who was consulted in this case, reported[1] that in his preliminary series he had 6 patients (one of whom was the case described in the present report) whose daily intake of pyridostigmin was 2,400 mg. or greater. In a more recent publication he presented 7 cases in this category[2]. The maximum daily dosage in his report was 6,000 mg. pyridostigmin. Rowland et al.[3] in a study of the effects of excessive doses of neostigmine in myasthenics achieved a maximum oral dose of 900 mg. per day, and an intravenous dose of 16 mg. given in 90 minutes. Schwab and Chapman[4] reported that some of their myasthenics required 450 mg. neostigmine orally per day. According to Goodman and Gilman[5] the usual daily oral dose of neostigmine varies from 15 to 375 mg. According to Eaton[6] some myasthenics require as much as 1,000 mg. neostigmine daily. Tether[1] reported three cases where the neostigmine intake was 1,680 to 2,700 mg. daily.

The patient described in this report indicates the extent to which cholinergic drugs may be required in tremendous dosage over a prolonged period. The ability of the myasthenic to tolerate, and indeed require such dosage is apparent from the fact that this patient for more than a year took with impunity daily doses which might well be fatal to the normal individual.

SUMMARY

A myasthenic patient is described who received an average daily dose of 2,415 mg. neostigmine and 8,940 mg. pyridostigmin bromide for one year without serious toxic reactions.

402 West Washington Boulevard

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Syndrome of Purulent Conjunctivitis, Marginal Keratitis, and Severe Non-Granulomatous Iridocyclitis*

T. F. SCHLAEGEL, JR., M.D.

WILLIAM T. SALLEE, Capt. USAF (MC)

Indianapolis

DURING THE SUMMER of 1953 a group of 7 patients was observed at Indianapolis General Hospital with a syndrome of severe purulent conjunctivitis, marginal keratitis, and severe non-granulomatous plastic iritis.

These patients were seen in June, July, August, and September of 1953. They were all adults and presented the following findings: (1) acute, severe, purulent conjunctivitis; (2) marginal keratitis with ulcer formation and corneal edema; (3) a severe non-granulomatous iridocyclitis characterized by an extreme number of cells, an unusually heavy flare, and in most cases a gelatinous coagulum which nearly filled the anterior chamber.

ETIOLOGIC FACTORS

1. In 5 of the 7 cases, conjunctival cultures were taken and revealed coagulase-positive Staphylococci: 3 were Staph. albus, and 2 were Staph. aureus.
2. Only 1 case presented a history of possible trauma—that of dust blowing into the eyes a day or so before onset.
3. Five of the 7 were Negroes.
4. The cases were observed only through the summer months, June through September, of 1953, and not before or since.
5. Most of the patients were in the advanced age group: 2 were in the 4th and 5th decades, while the others were all over 60 years of age.
6. The general health was only fair to good in all but 2 patients. One of these had excellent health; the other was markedly debilitated.

TREATMENT

Although the iridocyclitis could logically be assumed to be a toxic reaction to the staphylococcic keratitis and conjunctivitis, the reaction was so severe that the possibility of pyogenic endophthalmitis was considered. For this reason most of the patients were treated with systemic antibiotics, chloramphenicol being most frequently chosen. Local treatment was intensive and consisted of local antibiotics, local cortisone, and the usual cycloplegic and mydriatic drugs. All these patients received injections of Piromen* subcutaneously, given in increasing dosage up to a maximum of 10γ twice weekly.

COMMENT

Response to therapy in all these cases was prompt and satisfactory. Only two cases developed complications: Patient #6 developed a dense, vascularized corneal opacity but this patient was markedly debilitated and in the terminal stage of generalized carcinomatosis; and Patient #3 developed a cyclitic membrane in an aphakic, amblyopic eye. In all other instances the con-

* From the Department of Ophthalmology, Indiana University School of Medicine, and Indianapolis General Hospital. The authors wish to acknowledge the help of Dr. Louis N. Hungerford, Jr., Seattle, Washington.

* A sterile, non-protein, nitrogenous bacterial polysaccharide. The Piromen was supplied by Travenol Laboratories, Inc., Morton Grove, Illinois.

Patient	C.C.	Initial Examination	Treatment	Progress	Duration of Therapy
1. J. P. Age 78 Colored Female	Painful, red, swollen left eye. 6 days.	Marked, severe conjunctivitis; peripheral limbal infiltrates; cornea clear, anterior chamber clear. T. Tens. normal in both eyes. *Staph. albus coag.* +	Sulamyd Sol. & Oint. ½% Cortisone Sol. 1% Atropine Sol. Penicillin, 300,000 units, I.M. Piromen in increasing doses. 2% Zn SO_4 —paint cul-de-sacs.	By 5th day developed non-greasy K.P., large and pigmented. Flare ++++. Cells ++++. Began to improve on 7th day—continued to improve to complete resolution. 6 weeks later had intracapsular cataract extraction, R.E., with uneventful postoperative course and resultant good eye.	5 weeks
2. I. K. Age 59 White Female	Pain, burning, excess tearing photophobia, left eye. 8 days.	Marked, severe conjunctivitis with edema and subconjunctival hemorrhage. Scar in lower cul-de-sac with entropion, left lower lid. Pupil: mod. size, fixed. Eccentric corneal ulcer, dense infiltrates, hypopyon, plastic exudate. Flare ++++. Cells ++++. Numerous post. synechia. *Staph. albus coag.* +	Sulamyd Sol. & Oint. ½% Cortisone Sol. 1% Atropine Sol. Chloramphenicol, 250 mgm. q. 6 hr. Piromen in increasing doses.	Clearing began on 4th day. Synechia broken with 1% subconjunctival neosynephrine. By 10th day cornea was clear except ulcer, which decreased in size. Anterior chamber nearly empty. 14th day, chalazion removed from left lower lid. Discharge 16th day. Eye white. 1 mm. corneal opacity remained. Anterior chamber clear.	16 days (did not return to clinic for follow-up)
3. K. M. Age 65 Colored Female	Pain, redness. Foreign body sensation, R. E. 4 days.	Diffuse, marked, severe conjunctivities with edema. Stromal limbal infiltrates. Anterior chamber packed with gelatinous exudate. Flare ++++. Cells ++++. Bilateral aphakia. Visual Acuity: R.E. — amblyopia. L.E. — 20/30— *Staph. aureus coag.* +	Sulamyd Sol. & Oint. 1% Cortisone Sol. 1% Atropine Sol. Chloramphenicol, 250 mgm. q. 6 hr. Piromen in increasing doses. On 10th day stopped Sulamyd, started Terramycin Oint. 1%.	By 5th day cornea was clear. Anterior chamber had flare ++++. Cells +++. Vitreous opacity seen in superior portion of cavity. Eye continued to improve. Discharge from hospital 29th day. Followed repeatedly in clinic. Had one minor flare-up with increase in flare and cells; rapidly responded to treatment. After 9 months still has mild flare, no cells or K.P. Dense posterior synechia present with dense cyclitic membrane.	6 months
4. E. C. Age 32 Colored Male	Foreign body sensation. Pain, redness, swelling. Decreased vision both eyes. R.E. > L.E. 2 to 3 weeks.	Visual acuity: R.E.—20/100 L.E.—20/40 Severe conjunctivitis, purulent exudate, R.E.: severe conjunctivitis with edema and chemosis; marginal infiltrates and ulcers; wrinkles in Descemet's membrane. Flare ++++.	Sulamyd ointment ½% Cortisone Sol. 1% Atropine Sol. Chloromycetin, 250 mgm. q. 6 hr. Piromen. Subconjunctival neosynephrine 1%.	Rapid improvement of conjunctivitis. Corneas improved rapidly. Clearing of anterior chambers closely followed, although on 7th day mild flare and few cells seen in left eye. Visual acuity, 11th day: R.E.: 20/50; L.E.: 20/40. No flare, no cells, no posterior synechia either eye.	11 days

Patient	C.C.	Initial Examination	Treatment	Progress	Duration of Therapy
		Cells +. Many posterior synechia. L.E.: Severe conjunctivitis; cornea same. Many posterior synechia. Flare 0. Cells 0.			
5. M. C. Age 87 Colored Female	Pain, decreased vision, L.E., persistent and increased. 2 weeks.	Visual acuity: R.E. 20/100 L.E.: Light Perception. R.E.: Normal except cataract. L.E.: Mod. severe conjunctivitis with irregular limbal infiltration, ciliary flush. Pupil fixed. T. Tens. increased. Slitlamp: superficial corneal limbal infiltration; wrinkles in Descemet's membrane. Lower half anterior chamber filled with gelatinous exudate with cylinder of same material stuck to lens. Gross hyphemia. Flare ++++. Dense posterior synechia.	Sulamyd Ointment 1½% Cortisone Ointment. 4% homatropine q.i.d. Chloromycetin 250 mgm. q. 6 hr. Piromen. Subconjunctival neosynephrine 1%. Changed to 1% Atropine after tension, L.E., became normal.	Improved mod. rapidly with clearing of conjunctiva and cornea, followed by disappearance of cells in anterior chamber. Discharge on 15th day with flare ++, no cells. Seen in clinic 10 days later with flare ++++, cells +, gelatinous exudate. Had not been using Rx at home. Again rapidly responded to treatment. Cleared except for few residual cells which remained to 90 days. Treatment gradually withdrawn.	3 months
6. M. R. Age 74 White Female	Pain, redness, decreased vision right eye. 2 weeks.	L.E.: normal. R.E.: severe conjunctivitis, corneal limbal ulcer with deep corneal infiltration. Anterior chamber filled with gelatinous exudate. Flare ++++. Cells ++++. *Staph. albus coag.* +	Sulamyd Sol. & Oint. ½% Cortisone Sol. 4% Homatropine Piromen.	Anterior chamber gradually cleared in about 3 weeks. However, vascularization of cornea started and proceeded axially from limbus until cornea became completely opaque (almost porcelainized). Retained light perception. Tension soft. No pain. Treatment gradually reduced without flare-up.	2 months
7. J. S. Age 43 Colored Male	Pain, tenderness, redness, discharge, left eye. 6 days.	Vision: L.E.: 20/40 Purulent conjunctivitis 2 small limbal infiltrates. Flare ++++. Cells ++++. Tension normal. *Staph. aureus coag.* +	Sulamyd. 1% Atropine. ½% Cortisone. Piromen.	Rapid improvement of conjunctivitis and rapid clearing of cornea. Flare disappeared in 3-4 weeks but cells + persisted about 12-14 weeks. Cortisone discontinued very gradually. Result: normal eye with vision 20/20.	4 months

dition of the eyes returned to the pre-existing normal.

In this small series no correlation can be found between severity, rate of progress, or prognosis, on the one hand; and the duration of the process before treatment, age or general health on the other.

We doubt that these cases represent a new entity, but rather an extreme form of the toxic iritis frequently observed as a mild complication of the kerato-conjunctivitis due to staphylococci. Why the patients developed such a violent toxic iridocyclitis remains unknown. We could find no reference to such a syndrome in the literature, and Thygeson[1] and Allen[2] have never seen such a clinical picture. Braley,[3] who says he has never seen this clinical syndrome, feels that a non-granulomatous uveitis should occur with staphylococcal conjunctivitis, particularly if it is coagulase positive.

SUMMARY

Seven patients were seen in the summer months of 1953 with a syndrome of purulent conjunctivitis, marginal keratitis, and severe non-granulomatous iridocyclitis. Coagulase positive staphylococci were recovered in all cases tested but the severity of the iridocyclitis was much greater than routinely seen with staphylococcic conjunctivitis and marginal keratitis.

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Plan for First "Medical Education Week"

INDIANA PHYSICIANS will participate in a national mass education campaign culminating in the first nationwide observance of Medical Education Week from April 22 through April 28.

Chairmen representing each county medical society in Indiana will meet in Indianapolis March 18 to further plans for the campaign to focus national attention on the significance of medical education and the contributions of medical science to American life; and to create public interest, through knowledge, in the private support of medical education.

Spearheading plans for Medical Education Week in Indiana are the members of the Indiana State Medical Association's Committee on Medical Education and Licensure under the chairmanship of Dr. Maurice E. Glock, Fort Wayne. Other members are Drs. James W. Denny, Indianapolis; H. E. Klepinger, Lafayette; Wendell E. Covalt, Muncie; and William L. Daves, Evansville.

Cardio-Pericardiopexy: Report of Three Cases

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THREE MEN who had precordial pain due to disease of the coronary artery system received the Beck number[1] operation.[2] Each operation was performed by Dr. Claude Beck, Cleveland, Ohio. The purpose was to attempt to reduce the frequency and severity of the attacks by revascularization of the heart surface and to prevent or lessen the possibility of sudden death. Dr. Beck believes that a localized area of myocardial ischemia constitutes a trigger which at any time might precipitate an abnormal cardiac rhythm which would be incompatible with normal heart function.[1, 2] The operation is one in which the pericardial sac is opened and 0.2 gm. asbestos powder is sprinkled over the epicardial surface. The epicardial surface is then abraded. The coronary sinus is partially ligated to impede the return flow of blood to the right atrium. This sinus drains chiefly the left ventricular surface and its narrowing deliberately retards the blood return from this surface.

CASE I

A white male, age 43, had pain under breast bone radiating to left arm when seen in 1952. He had had pain in left arm since an accident in 1943 injured the upper spine. Other illness was a "strep throat" in 1943, and influenza in 1918. His father and an uncle both died following a coronary occlusion.

EXAMINATION: B.P. 140/80, rather pale, slightly overweight athletic type who appeared nervous. Eyes, ears, nose and throat negative. Chest, heart and lungs negative. Abdomen negative. Extremities negative. X-ray of cervical and thoracic spine showed calcification of disc between D 7 and D 8. X-ray of chest; heart normal size, lungs negative. Electrocardiogram in December 1952 showed an acute myocardial infarction.

MANAGEMENT: He was confined to bed for five weeks and remained at home until spring of 1953. Pain in chest and arm appeared on slight effort or while watching televised basketball games. He practically "lived on nitroglycerine". Many of the various coronary vasodilators were prescribed with little or no benefit.

PROGRESS: He tried to work at his job as a clerk in a hardware store from spring 1953 until May 1954 when he consulted Dr. Claude Beck in Cleveland, Ohio. Dr. Beck operated on him, noting "severe coronary artery disease" in his final report.

POSTOPERATIVE COURSE: By August 1954, he was able to work at his job with little pain and since January 1955 he rarely has need for nitroglycerine or other medication.

CASE II

A white male, age 37, was examined in June 1953 because of pain under breastbone radiating down left arm. Pain had been present about nine hours with onset around 4:00 a.m. He had had influenza in 1931, a severe illness in 1928 which was never diagnosed and a "heart attack" in 1940. His occupation was automobile salesman. His mother died of an acute coronary occlusion. The examination of this man showed him to be of the athletic build, slightly overweight, ruddy complexion. Temperature 99.8, pulse 90 and regular, B.P. 130/80. Eyes, ears, nose and throat were negative. Heart and lungs were normal to auscultation. Chest x-ray: heart was normal in size. Abdomen negative. Extremities, negative.

An electrocardiogram showed an acute posterior myocardial infarction.

MANAGEMENT: He was sent home to bed for four weeks and at end of that period was gradually ambulated. He continued to have fatigue and left arm pain but returned to his occupation in the fall of 1953.

PROGRESS: Despite the use of papaverine and paveril interchangeably from summer of 1953 to September 1954 he continued to have arm pain on exertion or emotional stress. In September 1954, he had another attack of chest and arm pain. He was again ordered to bed. The electrocardiogram did not show any new infarct, sedimentation rate was 35 mm. in one hour. From this time, he was confined to his home until January 1955 when he was sent to Dr. Claude Beck in Cleveland, Ohio. The operation was performed on January 14, 1955. He was found to have a solitary myocardial infarct and a generalized fatty degeneration of the myocardium.

POSTOPERATIVE COURSE: He suffered with pain along incision line and claimed to have limitation of motion in left shoulder. This complaint is still present in November 1955. The patient states that he tires too easily and has pain in left arm in the evening. He uses nitroglycerine frequently for relief of pain. Before surgery he could not work but since midsummer 1955 has worked full days.

CASE III

A white male, age 53, was seen April 1954 because of pain in stomach region, nervousness, and anxiety. He stated that gastrointestinal x-rays several years ago had shown a duodenal ulcer. He had been given ulcer management off and on since then but without any lasting relief. Another gastrointestinal series in 1954 showed a duodenal ulcer. The gallbladder visualized. An electrocardiogram at this time was entirely normal. B.P. 100/60. Pulse 68. He added that in past two years this pain seemed to move under breastbone and down left arm. Pain began with exertion such as climbing on railroad boxcars. He was a brakeman.

PAST HISTORY: He denied any serious illness. He was given 1½ gr. papaverine four times a day with little relief. The next time I saw him was November 16, 1954 when he had an acute attack of pain.

MANAGEMENT: He was admitted to the hospital. Temperature 98.6, sedimentation rate normal, no leucocytosis was found. The electrocardiogram on November 19, three days after entering hospital, was a normal record but was taken when he was free from pain. Daily he complained of epigastric and substernal pain early in the morning which was relieved by nitroglycerine (gr. 1/150). An electrocardiogram was taken during one of these bouts, 1/150 gr. nitroglycerine was administered, then after pain subsided another electrocardiogram was recorded.

During his stay in the hospital many vasodilators were used, peritrate, aminophyllin, papaverine, paveril, and metamine, separately, with no relief from attacks.

The x-ray of chest showed heart to be normal size, physical examination negative. His blood cholesterol was 185 mg., serology negative, sedimentation rate 5 mm. in one hour, prothrombin time 15.2 seconds, 61% activity. Urinalysis negative. Hemoglobin 14 gm.; red blood cells

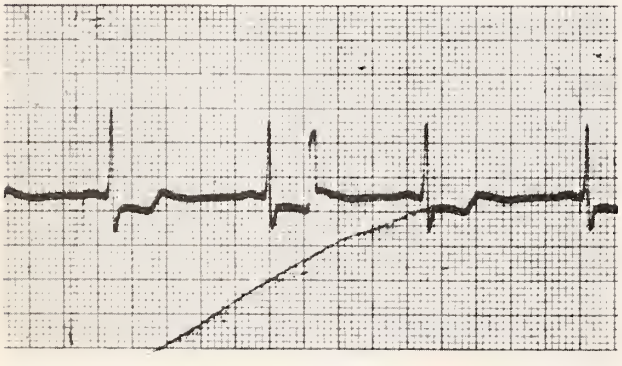


Figure 1. Chest V4 shows depression of ST with pain.

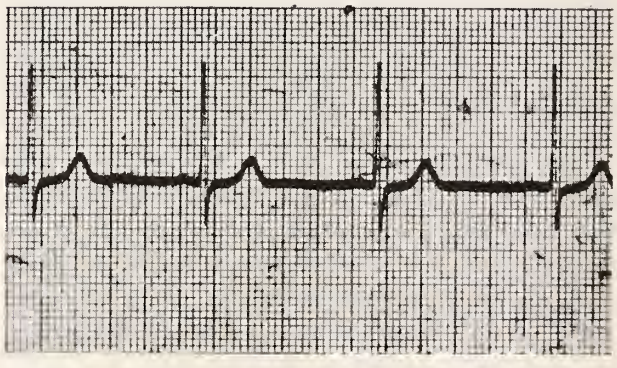


Figure 2. Chest V4 shows ST basal again after relief from pain.

4,850,000, white blood cells 10,850. His blood pressure, in hospital, averaged 130/80.

He was dismissed from the hospital December 26, 1954. Peritrate, 20 mg. three times a day was prescribed and in March was increased to 40 mg. three times a day without relief from pain. Finally 1/150 gr. nitroglycerine was the only medication given.

In June 1955 he went to Cleveland and was operated upon by Dr. Beck. While on the operating table he had an attack of tachycardia as coronary sinus was being partially ligated. The ligature had to be released. He was returned to his room and died suddenly about five hours postoperatively of ventricular fibrillation.

The autopsy showed there was extensive narrowing of the descending and circumflex branches of the left coronary artery. There were no myocardial infarcts found and the heart muscle was not degenerated.

DISCUSSION

Beck says in regard to good risk cases—"at least six months must have elapsed since last myocardial infarction" but those who never had an infarction and have only signs and symptoms of transient myocardial ischemia are better risks.[1, 2] He goes on to say that status anginosus is not a contraindication. The age group between 40 and 50 is the best. Some of the contraindications are a greatly enlarged heart, congestive heart failure or bundle branch block. Thompson[3] and Mazel[4] think that the "coronary cripple" may be helped by surgery. Thompson has operated 42 cases[5], of these 86% have shown more than 50% improvement. He uses sterile talc in place of asbestos. Mazel uses atomizers for spraying talc or asbestos powder and emphasizes persistence of new vascular channels after surgery.[4]

CONCLUSION

Patients in cases number 1 and 2 had infarctions and survived the operation. Patient number 1 is 75% improved. Patient number 2 is at least 50% improved, and he is now able to work full time. Number 3 never had an infarction but expired. All three had severe coronary artery narrowing and thickening. Heart size was normal in all three. One had a duodenal ulcer as a complicating factor in diagnosis. One had widespread myocardial degenerative changes seen at the operation; the other two did not.

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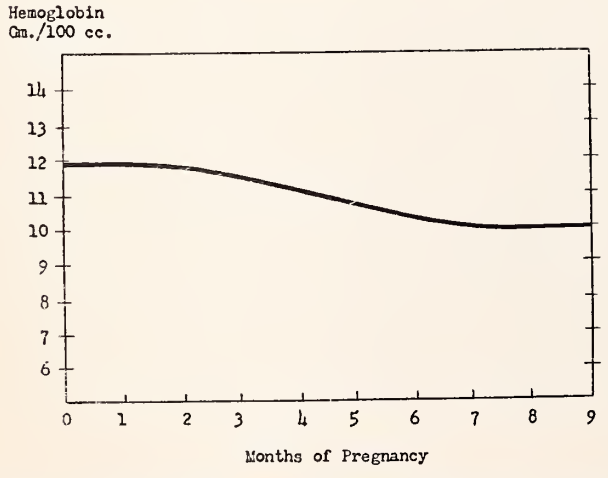
Anemias of Pregnancy

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PROBABLY THE MOST COMMON COMPLICATION of pregnancy is anemia. It is important, however, to distinguish between true or pathologic anemia, and the false or physiologic anemia of pregnancy. During pregnancy there is a normal increase of plasma volume of about 20 per cent, and a resultant dilution of the formed elements of the blood. Because of this dilution, which is progressive during the course of pregnancy, the *minimal hemoglobin value compatible with normality* decreases during pregnancy.

Chart I shows the progressive decline in this value, beginning with the value of 12 Gm. per 100 cc. at the onset of pregnancy and decreasing to 10 Gm. at about the seventh month. The curve, based on data from Sturgis,[1] Wintrobe,[12] Crane,[16] Wiehl[17] and others, is only an approximation since the rate of plasma dilution through pregnancy appears to vary from patient to patient. The red blood cell count declines approximately in proportion to the decline in the hemoglobin from a normal of about 4,500,000 cells per cubic millimeter at pregnancy's onset to 3,500,000 cells at the seventh month. The *apparent* anemia which results from the progressive dilution of the plasma is referred to by some investigators[1, 2] as the "physiologic anemia of pregnancy". It is probably not a pathologic or true anemia, although some workers[3, 6, 15] are convinced that it can be prevented by administration of pharmaceutical iron. We have followed the consensus and regard the dilution "anemia" resulting from the expansion of the plasma as a physiologic or normal phenomenon.

CHART I. HEMOGLOBIN IN PREGNANCY



In reviewing the anemias of pregnancy, it is apparent that considerable confusion is caused by variations in terminology. Holly[3] has classified the anemias directly related to pregnancy as follows:

1. Iron deficiency anemia, caused by iron deficiency.
2. Megaloblastic or macrocytic anemia, caused by folic acid deficiency, protein deficiency, or a combination of the two.
3. Hypoplastic anemia, the cause of which is unknown.

Of these anemias, by far the most common is iron deficiency anemia. Iron deficiency anemia is hypochromic and microcytic in type. The causes include loss of blood, maternal iron stores inadequate to meet the demands of the fetus plus the maternal needs, repeated pregnancies, prolonged low dietary intake of iron, and contributory dietary deficiencies, including those of

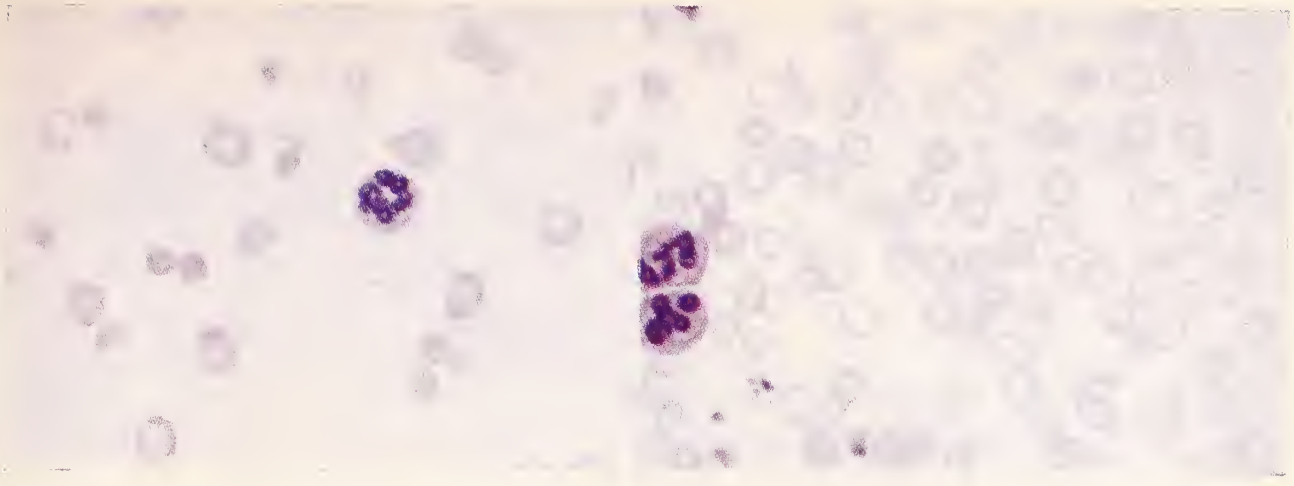


Figure 1. Photomicrograph of a blood smear in iron deficiency anemia.

Figure 2. Photomicrograph of a blood smear in megaloblastic anemia of pregnancy.

protein and certain B vitamins. The symptoms include pallor of the skin and mucous membranes, sore tongue, brittle fingernails, easy fatigue and lassitude, weakness, and increased susceptibility to infection.

The hematologic characteristics include a hemoglobin below 10 Gm. per 100 cc., red cell count below 3,500,000, mean corpuscular hemoglobin concentration below 30 per cent, mean corpuscular volume below 80 cubic microns, a normoblastic bone marrow and, frequently, achlorhydria. Specific therapy consists of administration of pharmaceutical iron, preferably ferrous sulfate, 510 to 680 mg. of ferrous sulfate, exsiccated, daily plus a diet generous in protein and vitamins. Figure 1 shows a photomicrograph of a blood smear in iron deficiency anemia.

The second anemia, megaloblastic anemia, also known as macrocytic anemia of pregnancy, occurs less frequently than does iron deficiency anemia, perhaps due to difficulties in diagnosis. This anemia is related specifically to folic acid deficiency and also to lack of ascorbic acid and protein. The symptoms are similar to those of iron deficiency anemia. In severe cases there may be diarrhea, nausea and vomiting, sore and bleeding gums, swelling of the extremities, severe mental depression, but no neurologic symptoms as occur in addisonian pernicious anemia.

Hematologically, the hemoglobin is below 10 Gm. per 100 cc. and the red cells below 2,000,000 in advanced cases. The mean corpuscular volume is normal or increased above 94 cubic microns. The mean corpuscular hemoglobin concentration is also normal or increased above 32 per cent. The bone marrow is megaloblastic. Free gastric hydrochloric acid is usually present. Specific therapy consists of the administration of 5 to 15 mg. of folic acid daily. In support, one should administer ample ascorbic acid and a diet generous in protein and vitamins. Combinations of these two most frequent anemias of pregnancy may occur. Their incidence is unknown and their diagnosis is difficult. Figure 2 shows a photomicrograph of a blood smear in megaloblastic anemia of pregnancy.

The overall incidence of anemia in pregnancy varies from 20 to 54 per cent, according to different reports in the literature.[1, 2, 3, 4] These reports substantiate the conclusion that anemia is a frequent complication of pregnancy.

The clinical study reported in this paper was designed to determine the incidence of anemia of pregnancy in a representative group of women, and to evaluate the efficacy of a prenatal nutrient capsule in preventing or treating anemias of pregnancy.

PLAN OF STUDY

The study was carried out at St. Mary's Hospital Prenatal Clinic, Evansville, Indiana. The subjects were 37 patients, ranging in age from 14 to 39 years, all from low income groups.

Physical examination, red blood count and hemoglobin determination were carried out on first examination. Thereafter, physical examination and hemoglobin determinations were made on each visit to the clinic. The Klett method for the determination of hemoglobin was employed.

Patients were asked to keep a daily record of their food intake from the time of the first

TABLE I. HEMOGLOBIN AND RED BLOOD CELL VALUES

NAME	AGE	RACE		FIRST MONTH		SECOND MONTH		THIRD MONTH		FOURTH MONTH		FIFTH MONTH		SIXTH MONTH		SEVENTH MONTH		EIGHTH MONTH		NINTH MONTH	
NP	19 yr.	W	Hb RBC				12.0 Gm. 4,010,000									11.5 Gm.	10.5 Gm.		10.5 Gm.	10.0 Gm.	12.0 Gm.
US	19 yr.	C	Hb RBC										8.5 Gm. 2,960,000	8.5 Gm.			9.5 Gm.	9.0 Gm.	9.0 Gm.	10.5 Gm.	10.0 Gm.
JL	17 yr.	W	Hb RBC												12.0 Gm. 3,910,000	11.0 Gm.		11.0 Gm.		10.5 Gm.	11.5 Gm.
MK	27 yr.	W	Hb RBC								11.0 Gm. 4,120,000					11.5 Gm.		11.5 Gm.		11.0 Gm.	11.0 Gm.
VI	18 yr.	W	Hb RBC											10.5 Gm. 3,550,000			11.0 Gm.		11.0 Gm.		10.5 Gm.
GN	17 yr.	W	Hb RBC										10.0 Gm. 3,250,000		10.0 Gm.	9.5 Gm.	10.0 Gm.	11.5 Gm.		11.5 Gm.	12.0 Gm.
MS	22 yr.	W	Hb RBC										10.5 Gm. 3,780,000		10.0 Gm.	10.5 Gm.		11.0 Gm.	11.5 Gm.		12.0 Gm.
KS	29 yr.	W	Hb RBC																11.0 Gm. 3,570,000	11.5 Gm.	11.5 Gm.
BU	21 yr.	W	Hb RBC												10.0 Gm. 3,080,000		10.5 Gm.	10.0 Gm.		11.0 Gm.	12.0 Gm.
LC	16 yr.	W	Hb RBC																		11.5 Gm. 3,960,000
HM	33 yr.	W	Hb RBC					12.5 Gm. 3,820,000				10.5 Gm.			11.0 Gm.		11.0 Gm.	10.5 Gm.	10.5 Gm.	11.5 Gm.	11.5 Gm.
WN	17 yr.	W	Hb RBC										10.5 Gm. ---		10.0 Gm.			10.5 Gm.	11.5 Gm.		12.5 Gm.
CF	31 yr.	C	Hb RBC																		10.5 Gm. 3,520,000
TH	17 yr.	W	Hb RBC											10.0 Gm. ---	10.0 Gm.		10.5 Gm.		10.5 Gm.	11.0 Gm.	
BM	16 yr.	W	Hb RBC			10.5 Gm. 3,010,000		9.0 Gm.		9.5 Gm.			9.5 Gm.		9.0 Gm.	9.8 Gm.		10.0 Gm.	9.0 Gm.	11.5 Gm.	
BH	34 yr.	W	Hb RBC											9.0 Gm. 3,430,000			11.0 Gm.	10.5 Gm.	11.0 Gm.	12.0 Gm.	11.5 Gm.
AX	28 yr.	W	Hb RBC												10.0 Gm. 3,390,000			9.5 Gm.	9.5 Gm.	10.5 Gm.	

JK	19 yr.	C	Hb RBC							9.0 Gm. ---	9.0 Gm.	9.5 Gm.	9.0 Gm.		9.0 Gm.		9.5 Gm.	9.5 Gm.	9.8 Gm.	10.0 Gm.	10.5 Gm.		
MK	28 yr.	C	Hb RBC						9.5 Gm. 3,380,000	9.0 Gm.	9.5 Gm.	9.0 Gm.			9.0 Gm.		9.5 Gm.	9.5 Gm.	9.8 Gm.	10.0 Gm.	10.5 Gm.		
TB	18 yr.	W	Hb RBC														10.5 Gm. 3,570,000	10.0 Gm.			11.0 Gm.		
CA	25 yr.	W	Hb RBC															12.0 Gm. 4,000,000	12.0 Gm.	12.0 Gm.	13.0 Gm.		
JW	14 yr.	W	Hb RBC													10.5 Gm. 3,400,300		11.0 Gm.	11.5 Gm.	12.0 Gm.	11.5 Gm.	12.0 Gm.	11.5 Gm.
NW	21 yr.	W	Hb RBC																	10.0 Gm. ---	10.5 Gm.	11.0 Gm.	
SB	34 yr.	W	Hb RBC					11.5 Gm. 3,730,000			10.0 Gm.	10.0 Gm.						10.5 Gm.	11.0 Gm.	12.0 Gm.	11.5 Gm.	11.0 Gm.	
JT	27 yr.	W	Hb RBC												10.5 Gm. 3,580,000		10.5 Gm.	10.5 Gm.	10.5 Gm.	12.0 Gm.	11.5 Gm.	12.8 Gm.	
MW	24 yr.	W	Hb RBC								10.0 Gm. 3,150,000		10.5 Gm.				10.5 Gm.	11.0 Gm.	10.5 Gm.	11.5 Gm.	11.0 Gm.	12.0 Gm.	
NH	30 yr.	W	Hb RBC														10.0 Gm. 3,440,000	11.5 Gm.		10.0 Gm.	12.0 Gm.	12.5 Gm.	
JS	21 yr.	W	Hb RBC														10.5 Gm. 3,430,000		11.0 Gm.	11.5 Gm.		11.5 Gm.	
HA	30 yr.	W	Hb RBC												11.5 Gm. 4,120,000		13.0 Gm.	13.0 Gm.		12.0 Gm.	12.5 Gm.	13.0 Gm.	
DW	29 yr.	W	Hb RBC												9.5 Gm. 3,480,000		9.5 Gm.	9.8 Gm.	10.0 Gm.	10.5 Gm.	12.0 Gm.	11.0 Gm.	
RN	39 yr.	W	Hb RBC					12.0 Gm. 4,220,000	10.0 Gm.		10.5 Gm.		11.0 Gm.		12.0 Gm.			11.5 Gm.		12.0 Gm.		12.0 Gm.	
ER	23 yr.	W	Hb RBC														11.5 Gm. 3,910,000		10.5 Gm.	9.5 Gm.	11.0 Gm.	11.0 Gm.	
RS	17 yr.	W	Hb RBC																	12.0 Gm. 3,950,000	10.5 Gm.	10.5 Gm.	
NR	14 yr.	W	Hb RBC												11.5 Gm. 4,080,000		9.5 Gm.	12.0 Gm.		12.0 Gm.		13.0 Gm.	
LL	21 yr.	W	Hb RBC																9.5 Gm. 3,330,000	9.0 Gm.	8.5 Gm.	9.5 Gm.	
MO	36 yr.	W	Hb RBC															10.5 Gm. 3,650,000	10.5 Gm.		10.5 Gm.	10.5 Gm.	
YH	15 yr.	W	Hb RBC															10.0 Gm. 3,340,000	11.0 Gm.	11.0 Gm.	11.5 Gm.	12.5 Gm.	

examination until date of delivery. Each patient's diet was supplemented with from 3 to 6 small prenatal nutrient capsules daily, in accordance with the blood picture. Three Natalins* capsules, the usual recommended intake, provide:

Vitamin A	6,000 units
Vitamin D	600 units
Ascorbic Acid	100 mg.
Thiamine	3 mg.
Riboflavin	4.5 mg.
Niacinamide	30 mg.
Pyridoxine Hydrochloride	0.6 mg.
Calcium Pantothenate	3 mg.
Folic Acid	1 mg.
Vitamin B_{12}	1 mcg.
Calcium	375 mg.
Phosphorus	188 mg.
Iron	22 mg.
(supplied by)	
Ferrous Sulfate, exsiccated	76.5 mg.

The capsules also contain traces of copper, zinc, manganese, magnesium and fluorine.

RESULTS

Hemoglobin levels and red blood cell counts are shown in Table I. Patients with two or more hemoglobin values below 10 Gm. and with a red blood cell count below 3,500,000 were considered as having frank anemia. Patients with two or more hemoglobin values of 10 Gm. or only slightly above were considered as having borderline anemia, provided their red cell count was proportionately low. All other patients were regarded as not having anemia, although certainly many did not have optimum hemoglobin stores and red blood cell counts.

Employing these criteria, seven patients, or 19 per cent, had frank anemia at some time during pregnancy. Five patients, or 13.5 per cent, had borderline anemia; and 25 patients, or 67.5 per cent, had relatively normal blood pictures.

Patients with hemoglobins above 10 Gm. per 100 cc. were given three prenatal capsules daily, containing a total of 76.5 mg. of ferrous sulfate,* in addition to other minerals and vitamins. Ten of the patients with frank or borderline anemia were given six capsules containing a total of 153 mg. of ferrous sulfate.* Two of the patients with anemia were given therapeutic doses of ferrous sulfate in addition to the six capsules. All patients who entered pregnancy with normal hemoglobin levels and red blood cell counts were given three of the prenatal capsules. All of these patients either maintained or increased their hemoglobin levels, indicating that the dose of 76.5 mg. of ferrous sulfate was adequate for preventing the development of iron deficiency anemia in these patients.

Megaloblastic anemia of pregnancy usually has its onset relatively late in pregnancy—about the seventh month. In view of the universal response of our patients to ferrous sulfate, it would appear that there was no megaloblastic anemia of pregnancy in this series.

Twenty-six patients kept daily diet records for periods varying from 1 to 4 months during the gestational period. Calculations were made on the basis of one representative day's diet chosen for each patient. The diets were fairly well balanced, with an average caloric distribution of about 15% of calories for protein, 34% fat and 51% carbohydrate. However, the intake of animal protein was low. The average intake of protein, calcium, iron and calories in terms of daily intake was as follows:

Protein	64 Gm.
Calcium	879 mg.
Iron	15 mg.
Calories	1807

exclusive of the nutritional contribution of the capsules.

Table II shows the approximate nutritional intakes based on one representative day's diet for 26 patients.

Table II. Approximate Nutritional Intakes

Nutrient	Low	Average	High
Protein (Gm.)	39	64	106
Calcium (mg.)*	382	879	1,438
Iron (mg.)*	6.4	15	34
Total calories	1,008	1,807	2,957

* The values for calcium and iron do not include the additional amount received from the capsules.

The average nutritional intake of protein, calcium, iron and calories was less than the Recommended Daily Dietary Allowance for pregnancy of the National Research Council

* Natalins, Mead Johnson & Company, Evansville, Indiana, who provided the materials used in this study.

* Exsiccated.

when the contribution of the prenatal capsules was not considered. Table III shows the Recommended Daily Dietary Allowance of the National Research Council and the per cent of patients below the recommendations, and therefore the per cent for whom a prenatal capsule was indicated.

Table III. Per Cent of Patients Below the Recommended Daily Dietary Allowance of the National Research Council

Nutrient	National Research Council	Per Cent Below	Number Below
Protein (Gm.)	85	88.5	23
Calcium (mg.)	1.5	100	26
Iron (mg.)	15	57.7	15
Total calories	2,400	76.9	20

There was no correlation between the levels of the dietary intake of iron and the incidence of iron deficiency anemia.

Anemia was the only complication encountered in any appreciable number in this series of patients. Two patients had mild preeclampsia, which did not develop into eclampsia. One patient had a stillborn due to torsion of the umbilical cord, and one patient suffered a postpartum hemorrhage. There were no other complications. Particular attention was directed toward the discovery of clinical findings such as neuritis; lip, mouth, tongue and skin lesions; vascularizing keratitis and diarrhea, and similar findings suggestive of a deficiency of one or more members of the vitamin B complex. An effort was also made to find evidence of calcium deficiency, such as leg cramps and other manifestations of increased neuromuscular irritability. In no patient was there evidence of either deficiency of the B vitamins or of calcium. Table IV summarizes the complications encountered in this study.

Table IV. Incidence of Complications

Incidence of	Number	Per Cent
Anemia (Hgb 10 Gm./100 cc.)	11	30
Preeclampsia	2	5.4
Stillbirth	1	2.7
Post-partum hemorrhage	1	2.7

DISCUSSION

The complications of pregnancy found in this study are in accordance with reports of other investigators.[1, 3, 5] Thus, mild preeclampsia occurred in 5.4 per cent of our patients, and others[5] reported an incidence of 4.5 per cent in their studies. Other studies report incidences ranging from 3.8 to 13 per cent.

Likewise, the incidence of anemia recorded in the literature is comparable to our findings. Sturgis[1] found that 54 per cent of pregnant patients observed at the outpatient department of the Universiy Hospital had anemia. Twenty-seven per cent had iron deficiency anemia, 15 per cent megaloblastic anemia and 12 per cent were believed to have a mixed anemia. In a survey of 4,015 pregnant women at the Charity Hospital, Lund[4] reported that half were anemic, according to commonly accepted standards. Benstead and Theobald[2] reviewed hemoglobin findings from 2,000 consecutive patients before the sixteenth week of pregnancy. They found that about 60 per cent of the patients were anemic and 6.5 per cent were severely anemic. Holly[3] stated that anemia occurs in at least 50 to 75 per cent of pregnancies if appropriate therapy has not been administered. If pregnant patients are not given additional iron, it appears that about 25 per cent will maintain their normal hematologic values throughout pregnancy and the puerperium. Fifty per cent will manifest slight to moderate decreases in blood values and 25 per cent will become moderately or severely anemic.

Of the anemias directly related to pregnancy, iron deficiency anemia is by far the most common. Treatment of this anemia consists of the administration of ferrous sulfate in amounts to provide 150 to 200 mg. of elemental iron daily* for at least one month.[1, 3, 6, 7, 8, 9] It should be recalled that response to iron orally administered is never dramatic or sudden. A prime aim of treatment is to replenish iron reserves in addition to the obvious correction of the hemoglobin deficit.

Megaloblastic anemia of pregnancy is a fairly rare occurrence. Nevertheless, it is serious when it does occur. A definitive diagnosis can be made only by bone marrow studies, although a presumptive diagnosis can be arrived at through study of a blood smear. Treatment of megaloblastic anemia of pregnancy consists of the administration of folic acid, 10 to 15 mg. daily.[1, 10, 11, 12, 13]

Hypoplastic anemia of pregnancy is quite un-

* Corresponding to 510 to 680 mg. of ferrous sulfate exsiccated.

common. Treatment consists of repeated blood transfusions as needed.

Holly[3] has shown that an iron deficit of approximately 500 mg. occurs during pregnancy as a result of maternal and fetal demands for iron. Moore [14] showed that only 5 to 15 per cent of dietary iron can be absorbed. For this reason, the woman must depend upon her iron stores to provide the iron required to meet the demands of pregnancy. Should these stores have been depleted by previous ill health, inadequate diet or repeated pregnancies, the chance for anemia is much greater.

Prevention of anemia depends, in part at least, on an adequate diet before and during pregnancy.[3, 6] A patient with partially depleted iron reserves at the onset of pregnancy will develop a moderate anemia. The patient with advanced depletion of the iron reserve may become extremely anemic as the pregnancy advances.

It would appear that a prenatal capsule with the composition of the capsules employed provides adequate amounts of iron and other hematopoietic principals, provided the patient enters pregnancy with normal iron reserves, and provided she does not develop folic acid deficiency anemia. This prenatal nutrient capsule does not seem adequate for the treatment either of iron deficiency anemia or of megaloblastic anemia of pregnancy, nor was it designed for such therapeutic use.*

SUMMARY

1. Twelve, or 32.5 per cent, of a group of 37 pregnant women had anemia at some time during the course of pregnancy. Of these, seven, or 19 per cent, had frank anemia and five, or 13.5 per cent, had what we have termed "borderline" anemia. All patients responded promptly to the administration of ferrous iron plus supportive therapy.

2. Of the patients who entered pregnancy with normal hemoglobin levels and red blood cell counts, none developed anemia during the period of pregnancy when maintained on three prenatal nutrient capsules daily, which provided 76.5 mg. of ferrous sulfate, exsiccated.

3. No megaloblastic anemia of pregnancy was observed in this series, probably due to the relatively small number of patients.

4. The incidence of complications of pregnancy, other than anemia, was low. Preeclampsia occurred in 5.4 per cent of the patients, stillbirth in 2.7 and post-partum hemorrhage in 2.7 per cent. There were no evidences of vitamin or calcium deficiency.

5. Analyses of the diets of the patients, based on a representative day's food intake, revealed that excluding the contribution of the prenatal nutrient capsules, 100 per cent failed to obtain sufficient calcium to meet the Recommended Daily Dietary Allowance of the National Research Council and 57.7 per cent had insufficient iron. Most of the patients were also below the recommended daily allowance for protein and calories.

* A special hematologic product, manufactured by Mead Johnson & Company, designed for pregnancy called Natalins-T, has been developed. Each Natalins-T provides 170 mg. of ferrous sulfate, exsiccated, and 3.3 mg. of folic acid. In the recommended dose of three capsules daily, the patient will thus receive 510 mg. of ferrous sulfate, exsiccated, and approximately 10 mg. of folic acid—therapeutic doses for iron deficiency anemia and megaloblastic anemia of pregnancy. Preliminary testing with Natalins-T has revealed that it provides a prompt hematologic response in iron deficiency anemia.

The sampling error of 32.5 per cent with a sample of 37 is 15.1 per cent at the 95 per cent fiducial limit. Thus, there is a 95 per cent probability that the true incidence of anemia for all pregnant women is between 17.4 and 47.6 per cent, assuming that our sample is representative. There is a 5 per cent chance that the true statistic is outside this range. If it is, however, it is almost certain to be very near 17.4 or 47.6 per cent.

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Vectorcardiography*

CHARLES E. JACKSON, M.D.

Bluffton

VECTORCARDIOGRAPHY is a subject which is unfamiliar to many physicians although it is not really a new field. To understand vectorcardiography one must first go back to the electrical axis concept of electrocardiography introduced by Einthoven, who considered the body to be similar to a flat plate of homogeneously conducting material with the heart at its center generating the electrical impulse. The two arms and the leg were considered to be points equidistant from the heart and equidistant from each other forming an equilateral triangle. With this concept one can derive the average direction of the electrical axis of the various complexes of the electrocardiogram. The concept that the standard limb leads could be combined into a single curve was first presented by Hubert Mann[1] in 1920. From three limb leads recorded simultaneously, electrical axes were derived at 0.01 second intervals. If the terminations of each of these instantaneous axes or vectors are joined, a loop is formed which Mann called the monocardiogram (Figure 1). This graphic construction did not receive extensive use because it is quite tedious and time consuming and requires simultaneously recorded leads. However, in 1936 and 1937 groups in Europe, and Wilson and Johnston[2] in this country, reported independently the use of the cathode ray oscilloscope to record automatically the loop which was termed the vectorcardiogram. This vectorcardiogram represented the average potential of the heart as it changed throughout the cardiac cycle—the electrical axis from instant to instant. Subsequently other groups have employed the cathode ray oscilloscope to obtain this vectorcardiogram. In the cathode ray oscilloscope the electron beam strikes the fluorescent screen, making a bright dot. If there is a voltage difference between the upper and lower plates, the electron beam is deflected up or down. If there is a difference in potential between the vertical plates the beam is deflected to the right or to the left and if there are voltage differences between both sets of plates the beam is deflected in such a way as to indicate the vector sum of the two voltages. Later a second cathode ray oscilloscope was used to record the sagittal view so that one could obtain an idea of the electrical activity of the heart in three dimensions—the spatial vectorcardiogram. Several different

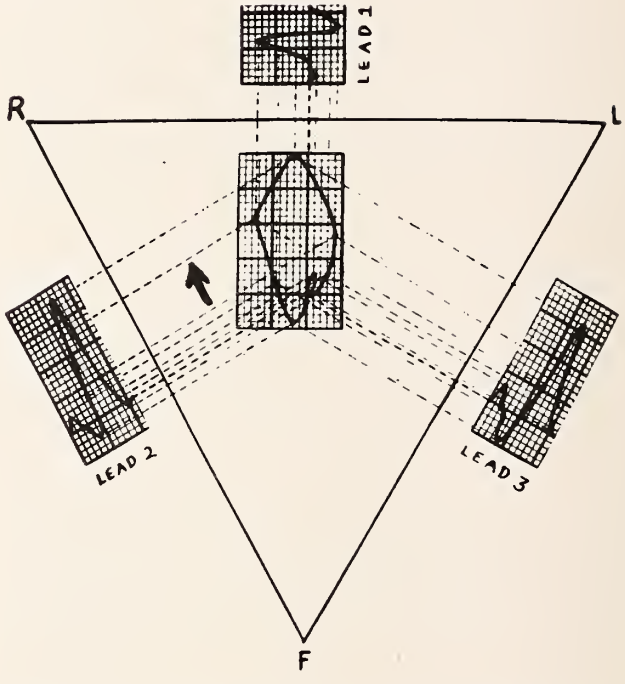


Figure 1. Derivation of the monocardiogram of Mann.[1] The loop must be turned end for end to be viewed as our present frontal plane vectorcardiograms are viewed.

* This study was sponsored by a grant from the Indiana Heart Foundation and by the Caylor-Nickel Research Foundation.

Presented before the Section on Medicine, Indiana State Medical Association, October 27, 1954, and submitted for publication with revisions at a later date in 1955.

methods of electrode connection from the patient to the cathode ray oscilloscopes are in use to record this spatial vectorcardiogram such as the equilateral tetrahedron reference frame of Wilson and associates[3] (Figure 2) and the cube system of Grishman and Scherlis[4] (Figure 3). The many reference systems used by various groups has resulted at times in great difficulties in interpretation of vectorcardiographic data. There has been some standardization of methods of presenting vectorcardiographic data but one of the big needs in vectorcardiography is the standardization of reference frames. Since no perfectly ideal system is likely to become available, a somewhat arbitrary system will have to be accepted eventually. One of the advantages of the tetrahedron system is that only one more electrode position is required in addition to those used to record the standard limb leads, making the electrode positions simple to use technically. Another advantage is that all the vast experience in interpretation of limb leads can be applied to the interpretations of this type of vectorcardiogram. With the help of a grant from the Indiana Heart Foundation we have constructed a mobile vectorcardiograph (Figure 4) with which we are collecting clinical data on various cardiac abnormalities. From the photographs of the loops on the cathode ray oscilloscopes, wire models are constructed to give the three-dimensional aspect. There is evidence that we are able to separate normals from abnormals better by vectorcardiography than by electrocardiography in that positional changes are more readily identifiable.[5] It is hoped that vectorcardiography may help indicate infarction in patients with intraventricular conduction defects and there is some indication that vectorcardiography may help demonstrate hypertrophy in the presence of intraventricular block. Vectorcardiography may be helpful in separating normal individuals with positional Q 3 changes from those with posterior myocardial infarction[6]. Vectorcardiography fails in certain instances to detect focal myocardial abnormalities detectable readily by multiple precordial leads. One does not obtain nearly as good evidence of some anterior infarcts by vectorcardiography as provided by the multiple precordial leads and it is because of these instances that I feel vectorcardiography will not replace our conventional electrocardiograms, but will be of supplementary value in selected cases.

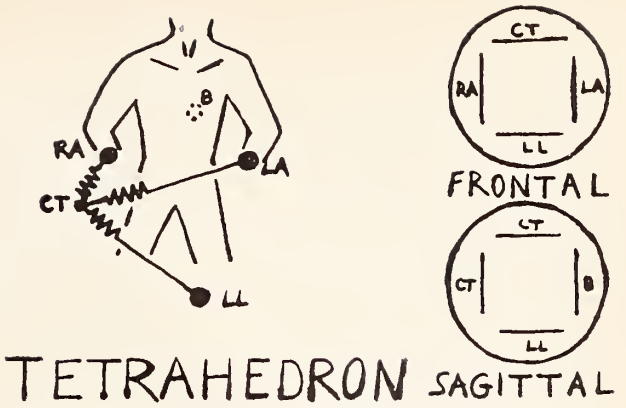


Figure 2. Equilateral tetrahedron reference system, illustrating lead connections to the cathode ray oscilloscope plates.

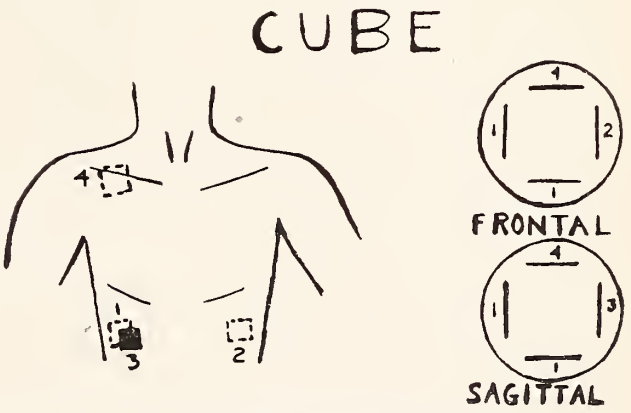


Figure 3. Cube Reference System—electrode positions:

1. Right posterior axillary line at level of 1st to 2nd lumbar vertebra.
2. Left posterior axillary line at same level.
3. Right anterior axillary line at same level.
4. Over right scapula posteriorly.



Figure 4. Photograph of mobile vectorcardiograph.

SUMMARY

Vectorcardiography gives promise of giving information not obtainable by conventional electrocardiography and of being of real clinical value in selected problems. Though not a new field, vectorcardiography still lacks sufficient study to indicate what real clinical value it may possess. It lacks autopsy correlation in any sizable series of cases. Most attention has been focused on the QRS vectorcardiographic loop with little attention on the T loop and even less on the P loop. The vectorcardiogram does not give very accurate information about time relationships of the various electrocardiographic intervals but this objection can be circumvented by recording simultaneously one of the usual electrocardiographic leads. It is improbable that vectorcardiography will replace conventional electrocardiography because it fails in certain instances to detect focal myocardial abnormalities detected by the multiple precordial leads.

About 1923 Sir Thomas Lewis gave up electrocardiography because he felt it had nothing more to offer after having helped elucidate the arrhythmias. At this time we can no more predict correctly what impact vectorcardiography may have on medicine than could Sir Thomas Lewis predict the future impact of electrocardiography at that time. Though strictly a research field now, vectorcardiography does give promise of being eventually of real clinical value.

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POPULATION SHOWS SHARP UPSWING

THE POPULATION of the United States has increased in the past 10 years by about 26 million. This increase is larger than that for the 21 years prior to 1945. According to population estimates as published by the statistical department of the Metropolitan Life Insurance Company, U. S. inhabitants now number 166,740,000.

The increase, which started to be accelerated at the end of World War II, is due to a tremendous baby boom, to favorable health conditions, and slightly to immigration.

There has been an average of 3.8 million births since 1945. Each of the past five years has successively set new high records.

Each year has also seen a decline in infant mortality. In 1955 the rate was a new low—26.4 per 1,000 live births. This is about 1½ percent better than 1954, and 30 percent below the rate for 1945.

The death rate in 1955 was 9.3 per 1,000, very close to the 9.2 rate in 1954 which was the all-time low.

Indiana is enjoying population increases which are in excess of that of the nation as a whole. The state now stands at 4,377,000—a 2.2 percent increase in 1955 and an annual average increase since 1950 of 1.8 percent. The entire country increased at the rate of 1.7 percent.

Indiana is in a median position as compared with neighboring states. It was exceeded in population increase by Michigan and Ohio, and was better than Illinois and Wisconsin.

The Pacific states are showing the highest rate of increase as compared with other regions, 3.3 percent in 1955. The increases for Nevada and Arizona were the largest of all the states. Florida and Delaware are also near the top. Michigan, Ohio, Connecticut, New Jersey and Maryland are well above the national average.

Five states decreased between 1950 and 1955—Alabama, Maine, Mississippi, Arkansas and Oklahoma, although only the last three named showed a decrease during 1955.

PEACETIME USES OF THE ATOM

ELI LILLY AND COMPANY has announced the contribution of funds, together with about 25 other companies, for a cooperative project to build and study the industrial uses of an atomic reactor.

The participating companies all will be members of a reactor study group of the Armour Research Foundation of the Illinois Institute of Technology. In addition to aiding the financial plans for the reactor, the cooperating members will suggest research projects, and may be able to utilize the reactor when it is not being used for research purposes.

Lilly's research department is interested in exploring the possibility of sterilizing products by radiation. Another possibility for investigation is the improvement of yields of antibiotic substances from molds and bacteria grown for this purpose. It is also expected that the reactor may produce isotopes for use in pharmacologic research.

This is another example of the willingness of Eli Lilly and Company and of American industry in general to share in high-cost research and development and in the results thereof. While the cost of such research might be borne by a few organizations, the pooling of talent and know-how of many companies will contribute to the early solution of industrial problems. No matter how high the cost in money and work, the results to be expected will far outweigh the expenditures.

MEDICAL ASSISTANTS' SOCIETY

MEDICAL ASSISTANTS GROUPS are becoming better and better organized. Like most good organizations the movement started in a relatively small way and has grown more or less spontaneously ever since. Some of the original clubs were organized in cities and later became countywide organizations. State associations were formed next and now there is considerable sentiment in favor of a national society.

Enough interest had been generated among the various state and county societies to warrant a national association founders meeting in Kansas City last fall. Fifteen states were represented by 75 attendants, and the necessary constitution committee was formed and a date was set for a meeting in Milwaukee next fall.

The objectives of these societies are educational. They were formed for the purpose of acquainting doctors' office assistants with as much information as possible on the "three-ring-circus" job of insurance blanks, meeting the public, answering the phone, keeping track of the doctor, keeping track of the accounts, and maintaining equanimity all at the same time.

Members of county medical societies have served as advisors for the various groups. County and state medical organizations have assisted in the formation of the assistants' clubs, and have helped in planning their educational programs.

At present there are several county units in Indiana.

The Indiana State Medical Association is exploring the possibility of sponsoring a state organization. Office assistants who are members of the Indiana county societies are enthusiastic and are sure—to quote from one of the state constitutions—that they have been inspired "to render honest, loyal or more efficient service to the profession and to the public."

Guest Editorial:

Note: The following comments were presented to members of the Junior class of the Indiana University School of Medicine by Robert P. Acher, M.D., Greensburg, a member of the Subcommittee on Preceptorship of the Indiana State Medical Association. Dr. Acher was one of the panelists on the special program.

MEDICAL PRACTICE

THERE IS A VAST difference between the medical center type of medical practice and general practice. In medical center practice your patients are assured. The prime interest is in the disease and in a rational and logical gamut of procedures that establish diagnosis and eliminate the disease. Of course the patient as a whole is taken into account because the disease affects that patient as a whole but the prime interest is in the disease and its eradication.

● In general practice the interest is also in the disease and its eradication but with this added factor—the patient, not the professor, is evaluating your work and believe me, there is a vast difference. I believe this is the crucial point in the difference between medical center practice and general practice. It may give rise to great misunderstanding, heartbreaks and mental anguish to the doctor if not fully appreciated.

● How does the patient evaluate your work? I can assure you it is on an entirely different basis than your teachers or professional colleagues. Fundamentally the patient judges your work on how well he likes you and your treatment of his illness.

● Therefore it is imperative that you make people like you and you cannot do this effectively if you do not have an intelligent and wholesome regard for yourself. So the fundamental point in all this is to have an intelligent and wholesome understanding, acceptance, and a liking for one's self. From the time of Confucius to the present, most of the great thinkers of history have included somewhere in their writings the advice to "Know thyself". There must be something in it.

Now we have the paradoxical situation of our success in the practice of medicine depending on something other than what we learn in school, and I would like to say here and now that the art of medicine is the correlating of these two factors.

Our personal integrity and intellectual honesty requires that we give our patients the very best we can in technical knowledge in the study of his disease, whether he appreciates it or not.

The field of medicine is becoming increasingly technical and the body of knowledge embraced by medicine is too great now to cram into four short years of medical school. Therefore, it behooves you now to devote your energies to getting around as much of this knowledge as you possibly can—make it your own, develop a basic philosophy of self understanding, open mindedness, awareness of changing concepts, and humility, and you can handle the problems of general practice as they arise.



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The President's Page

ON COMMITTEES

THOUGH I HAVE been connected actively with the operations of medicine for many years, the actual value of our multiple committees recently has been an eye-opening surprise. Almost 200 men are presently serving on committees, at a definite personal loss of time and money, actuated solely by a sense of duty to the profession and an earnest desire to contribute something to the advancement of medical care.

It is a heart-warming experience to attend these committee meetings and observe the serious attempts to winnow the good ideas from impractical suggestions. I have never heard anything proposed that even resembled personal advantage; it has been solely a question of professional and public good. And this observation brings me to a discussion of committee membership.

I think members should be recruited from every part of the state so that every section is represented. There is constant need of new blood, of new views which are alive to social and economic changes. There always should be a substantial representation of the older and more experienced men to act as a balance wheel but young men should be drafted, if need be. For years it has been easier for the appointing power to merely copy former lists, sure of cooperation. But no provision of policy forbids selection of many new men. Those younger men are busy building practices and are understandably reluctant to take on unpaid duties requiring absences from home. However, they can be found and it is surprising how enthusiastic these young men become. It requires solicitation and personal urging to secure the services of these younger men but the effort is rewarded.

To be asked to serve on a committee is an honor, a recognition of ability, and of deep interest in the affairs of medicine. Because of the continuing interest, always accentuated by close contact with other minds, the welfare and progress of the profession advances. The profit of such service is not in dollars but the rewards in mental satisfaction and widening of views are ample pay for they continue through life. As a veteran in society service, I assure the younger group there is no greater or more comforting reward in life.

I think the head of the profession should drop in on every committee meeting possible even though it means use of much time. The work of committees should be coordinated, there should be inter-committee conferences to avoid overlapping effort . . . all to the general good.

I here desire to record appreciation of the splendid work of our present committees. They are the backbone of our Association.

W. H. Kennedy

The Woman's Auxiliary

REPORTS TO I.S.M.A.

We are thinking of the close of the Auxiliary year, reports to get ready for the House of Delegates which is to be held in Gary on April 26 and 27. This is always a stimulating conference where we make new friends, greet old ones and report the accomplishments of our respective Auxiliaries.

Our regular assignments are well in hand. Some of them are helping build a stronger organization.

Editing and publishing a state magazine, "The Hoosier Doctor's Wife" is an accomplishment of which we are especially proud. It is one of the outstanding state publications in the Auxiliary. It is sent to each member of the Auxiliary to the Indiana State Medical Association. At the recent board meeting it was voted to make the Editorial committee a standing committee. The Bulletin chairman promotes the distribution of the national magazine. The legislative chairman is alert to relay any pertinent information on medical legislation, either on the state or national level. Auxiliary members serve as a backlog of support, both in their own groups and in stimulating right medical thinking in the lay groups to which they belong. Other projects: "Today's Health", American Medical Education Foundation, nurse recruitment, mental health and public relations are vital, and work of those committees is progressing steadily.

We, however, need help in promoting more Health Education Days. The Auxiliary, at state and local levels, is eager for every county medical society to consider putting on a program, letting the Auxiliary make arrangements as to place and publicity. Last month we devoted most of this page to this project because both the Rural and School Health Committees of the Indiana State Medical Association and its Auxiliary feel that it is vital.

Two other projects have come to our attention recently. First, the encouragement of high schools to take part in Science Fairs. Quoting from Dr. W. U. Kennedy, President of I.S.M.A., "This nation needs to do all it can to interest youth in the field of science if we are to keep ahead of the rest of the world." In an effort to help develop more scientists, the Indiana State Medical Association is sending two students from each of the eight regional fairs to the National Science Fair in Oklahoma City May 10-12. Auxiliary members are asked to do what they can to help encourage participation in these Science Fairs. The second new project is sent to us from the Auxiliary to the American Medical Association. Following the lead of the Pulaski County (Arkansas) Medical Society they ask us to encourage a survey of charitable and community activities of physicians in order that concrete figures and statistics may be used to refute the repeated statement that professional men do not assume their fair share of community responsibility. This advance information is passed on to you for your consideration.

We stand ready to undertake any responsibility which you wish to delegate to us as an Auxiliary.

Sincerely,

Helen W. Mather

Mrs. J. Winford Mather, President

Another Field of Preventive Medicine

C. O. McCORMICK, M.D.

Indianapolis

DURING RECENT YEARS an increasing minority of physicians have included in their practice, what rightfully can be termed, a new branch of preventive medicine; namely, "Premarriage Counseling." The interest in this field is being stimulated by a growing conviction the medical profession, though singularly qualified, is not assuming its share of the responsibility of the stabilization of our American homes by aiding in the creation of better marriages.

It is regrettable and quite a deplorable commentary that one marriage in three in this country terminates in divorce. One can only conjecture what increased strength this nation would possess as a leading world power were not so large a percent of its basic units, the homes, thus involved. As a matter of fact, this 30 percent represents only the *legally* divorced couples. Another huge percent for all practical purposes are divorced, although the civil registries do not list them as such. Every physician is impressed by the very few serenely and sublimely happy couples he encounters. Many doctors, having had a lifetime practice, can enumerate them on less than 10 fingers.

Some astonishing figures in this respect were revealed in a five year survey ending January 1, 1955, taken in the county clerk's office of Marion County. For every 100 marriage licenses issued there were 73 divorces filed. Shortly prior to this period, in one month there were more divorce suits filed than there were marriage licenses issued. During this same five year period for every 100 marriage licenses issued there were 42 divorces granted. If similar surveys were made in other counties, one could venture these statistics of Marion County would seem comparably less appalling.

A vast majority of individuals agree certain divorces are justifiable. On the other hand, when a child is involved, it would appear its inalienable right to natural parenthood and wholesome home influence would dictate an inescapable moral duty on the part of both parents, one that should hold high priority over several factors and circumstances upon which many divorces are granted.

To come quickly to the point, society's concern in disrupted homes is not primarily because of their shortcomings in connubial bliss and ecstasy, but rather in the frequent residue, juvenile delinquency. It is reported 1 American child in 13 today is in difficulty with the law. Ninety percent of juvenile delinquents come from broken homes. This is borne out by the universal observation, "A child in really serious trouble rarely comes from a good home." In this instance, "good" is not synonymous with "wealthy." It is significant to note that four decades ago the average age of a criminal was somewhere near the middle thirties. Today it is 24 years.

From these facts it is clearly indicated the creation of better homes is the key cue to the solution of our nation's number one social problem. Much, if not most, of this can be accomplished through the preventive measure of thorough, bona fide preparation for marriage on the part of both parties. Once domestic relationships have been strained, it is extremely difficult to rectify them; and wrecked homes are rebuilt, if ever, with extreme difficulty.

Such preparation, in addition to the usual physical and family history requirements might properly demand that after an application for a license an indoctrination course be taken during a statewide imposed statutory waiting period. The curriculum of such a course would cover such subjects as "Sex in Marriage", "Intelligent Planning of Pregnancies", "Child Rearing and Discipline", "Religion and Marriage", "Family Budgeting", "The Wife's Obligations to the

Home", and "The Husband's Obligations to the Family".

An adequate staff would consist of a physician, a minister, a sociologist, a banker and a business man. Regularly scheduled meetings could be held in school buildings, churches or libraries. Before granting a license, all applicants, except those presenting satisfactory credentials obtained through high school or college courses, would be required to furnish a certificate of attendance to such indoctrination courses. This restriction would particularly apply to cases of remarriage.

We prepare and educate for all other principal life endeavors; why not for marriage, the most engaging of them all.

Admittedly, this approach appears unwieldy. Also, admittedly, we are dealing with a problem that perniciously attacks the foundation of our society and in turn the future of our nation. And again, admittedly, the entire situation is a growing ball of wax encasing many entanglements. However, be all this as it may, from here it appears the solving of the problem of building our homes more securely will have to be achieved sooner or later along the lines herein briefly suggested.

Of the four major causes of divorce, sex, finances, liquor and in-laws, sex is by far the predominating factor, being involved in fully two-thirds of all divorces. Frequently this is illustrated well when in investigating the cause of a divorce, this retort is heard, "Do you want to know the real cause or the reason we gave the court?"

Sex difficulties are attributed to sex ignorance and sex misinformation. This lack of knowledge is shared by the young, the old, the rich, and the poor. Couples sexually adjusted rarely seek divorce, even though other family affairs go wrong. *Marriage can be freed of its chief disharmony, only by the abolition of sex ignorance.* It is here the medical profession finds both its opportunity and responsibility. No other group is so intimately qualified.

The profession should assist in seeing that courses for marriage preparation are amply provided not only in our colleges and universities, but high schools as well. Because a large percent of high school graduates do not enter college, and are prone to marry young, such provision is important. *A large percent of divorces result from immaturity.* Here again the profession should contribute by actively seeking a mandatory law requiring proof of age before issuance of license to prevent minors falsifying their age with or without their parents' approval. Also, the medical profession should assist in obtaining a legal provision making the minimum time for issuing of license five days after making application. This is especially applicable to youthful marriages. The cooling-off period would correspond to that required by most states in the final granting of divorce.

That the requirements for a marriage license are far from too restrictive was shown in the previously mentioned five year survey, in which only one couple in 210, or less than one-half of one percent, did not qualify.

No individual of any organized group, social, legal, or ministerial, holds the intimate relationship and understanding of family problems and frustrations as does the doctor. The timeworn phrase, "The minister gets their flowers, the attorney gets their troubles, and the doctor gets them just as they are," is most appropriate here.

Despite the fact each physician has taken an oath to serve humanity as to its physical and psychologic ills, a majority of us continues to shy away and openly manifests a reluctance in serving our families of their marital ills.

We do this although fully aware of the manifold and potential evils resulting from the disharmony of broken bonds of wholesome family life. We see despair and frustration in their most painful form. We see love converted into fiery hate. We see faithfulness and loyalty cast to the winds. We see ostracized and outcast children deprived of parental love, affection, and spiritual guidance. We see them as juvenile delinquents committing crimes all the way from vandalism to murder. We see them as seedlings of master criminals. We see them as charges of the state with their minds distorted and filled with grievances against society. We see them wanting physically as to adequate diet and disease protection.

Yes, the social worker, the lawyer and the minister are as cognizant of all this as doctors are. But when it comes to alleviation the one gross difference is that neither of them possesses the intimate and confiding relationship to the family or has the basic understanding of its frustrations as does the physician. No other

public servant is as close to the hearts and hearthstone of the family.

Because of this singular and select position, the physician is superiorly qualified to serve in the field of creating better marriages. With the national problem of broken homes and the baffling sequence, juvenile delinquency, on the increase, the medical profession should recognize the betterment of our marriages as a distinct form of preventive medicine, and should assume an active lead in this important, though neglected, field as a righteous obligation and forthright duty.

* * * *

"No man and wife can work well for the nation and common good unless they are deeply rooted in a home."

621 Hume Mansur Building

A.M.A. Public Relations Director to Speak at March 18 Conference in Indianapolis

"WHAT YOUR PATIENTS SAY About You" is the title of the luncheon address which Leo A. Brown, public relations director of the American Medical Association, will give before a joint Conference of County Medical Society Officers and Medical Education Week chairmen in the Sheraton-Lincoln Hotel, Indianapolis, on Sunday, March 18. Mr. Brown's resume of a recent survey will reveal the fact that a substantial majority of the citizens queried in a cross-section sampling were well-pleased with their medical care.



Leo A. Brown

You won't want to miss hearing what "they say".

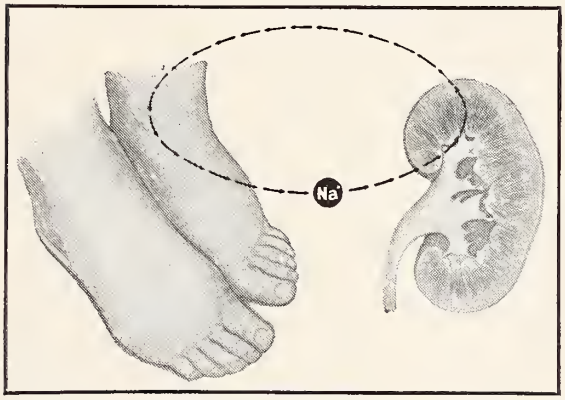
Full details of the program were released by the headquarters office of I.S.M.A. This annual get-together by officers of each county society furnishes an excellent opportunity for the exchange of information among physicians from the entire state. Chairmen from the county societies who will plan a concerted program to arouse interest in the American Medical Education Foundation are also urged to attend.

Remember it's March 18—Sunday—at the Sheraton-Lincoln Hotel in Indianapolis.

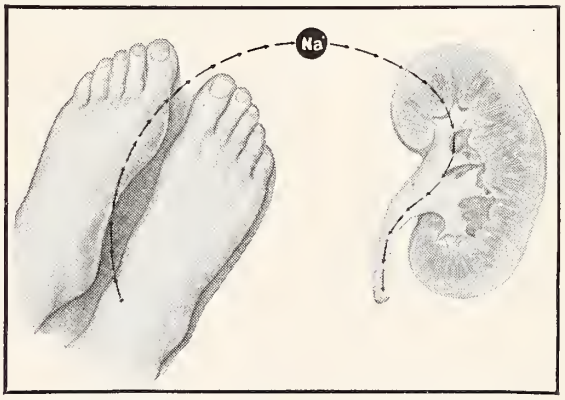
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Clinically, Mictine is useful in the maintenance of an edema-free state in all patients and for initial and continuing diuresis in mild or moderate congestive failure. It is not intended for initial diuresis in severe congestive failure unless either sensitivity or tolerance to other diuretics has developed in the patient.

The maintenance dosage of Mictine, as well as for initial diuresis in mild or moderate congestive heart failure, is one to four 200-mg. tablets daily in divided doses; the dosage for initial diuresis in severe congestive failure, under the conditions already described, is four to six tablets daily. For either use, it is recommended that Mictine be prescribed with meals on interrupted dosage schedules; that is, prescribing Mictine on alternate days or for three consecutive days and omitting it the next four days.

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Doctors' Dilemma

Britain's State Medicine Poses Problems For Physicians—And for Nation's Health

By RUSSELL KIRK

RECENTLY in Scotland I had occasion to go to a doctor, and though there was nothing very wrong with my health, I did obtain some idea of what is wrong with Britain's National Health Service and socialized medicine in general.

Like nearly all doctors in Britain, this one, whom we shall call Dr. MacIntosh, has come into the National Health Service. Doctors engaged full-time in private practice are scarcely to be found beyond the bounds of London's Harley Street, for inflation and taxes have made it difficult for anyone except the very rich to engage the services of an old-fashioned private physician.

Dr. MacIntosh's consulting rooms are in what once was the servants' lodge of a Victorian townhouse, where the doctor now lives. The waiting-room— a long, barren place, formerly the servants' hall—was the antithesis of the anteroom of a successful Victorian or Edwardian physician. It was cold and dreary. There was no receptionist; there were no books or periodicals, no pictures on the walls; only some 20 hard little folding chairs. When I came in, the room was full. Most of the men and women were elderly and rather shabby, but none looked particularly sick.

At length my turn came, and after Dr. MacIntosh had examined me, we talked a while. "You seem to have a great many sick people in this town," I said. "Not so very many, really," said Dr. MacIntosh. "A great many old people in this town, especially, yes."

NOTHING TO DO

"And you're able to treat them very quickly," I remarked. "Treat them?" he replied. "Not one-fifth of those people you saw require any treatment. They're old, and they have nothing to do, so they come to sit in my waiting room, and make me fill out forms for them. After all, this is the next best thing to the cinema."

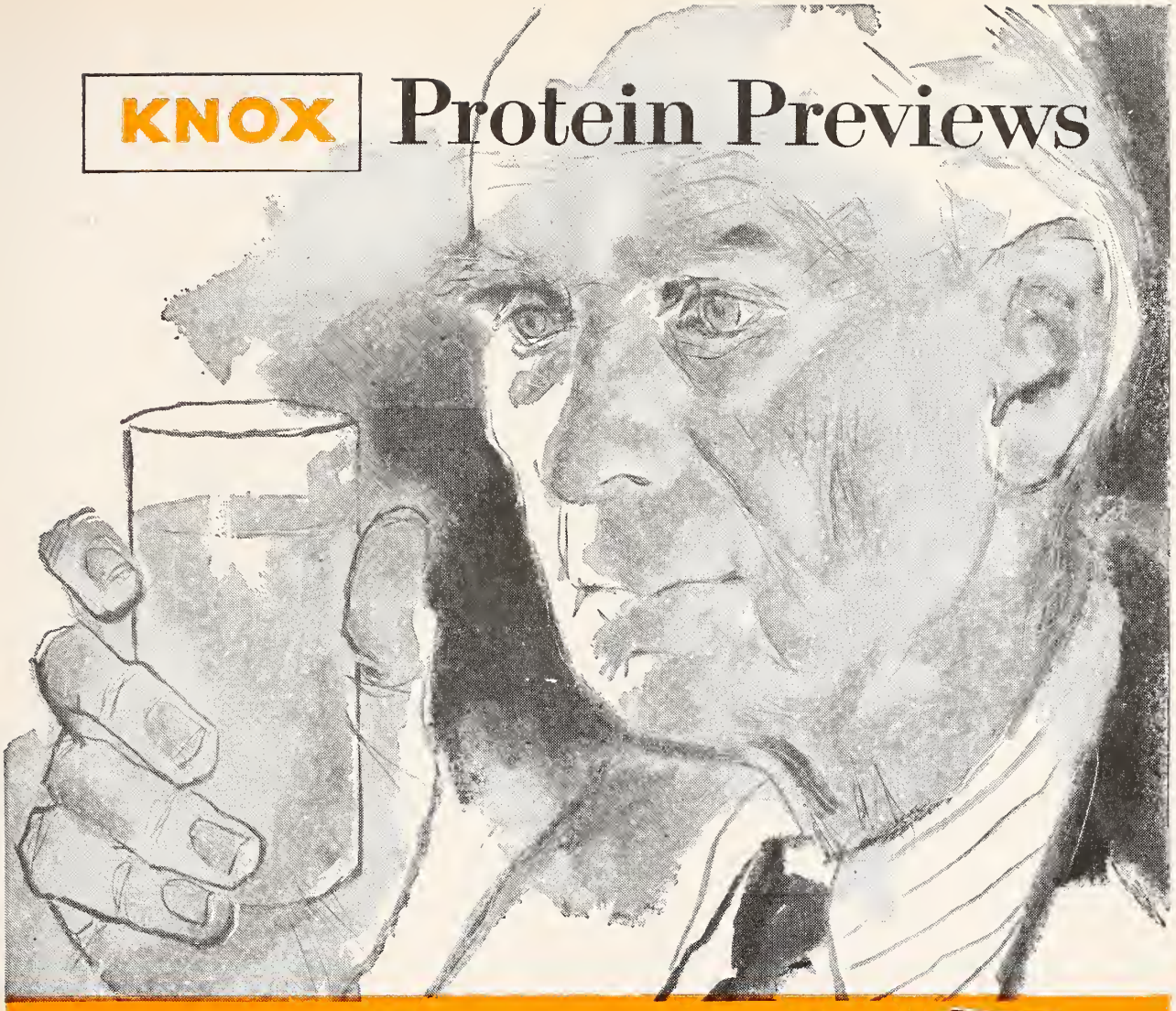
"If they're hypochondriacs, can't you turn them away?" I asked. "That would not be prudent, in most cases," he explained. "People like that are liable to complain to the National Health Service. And the doctor can be fined, you know, by the Service; and he can be struck off the Service's list. Besides, the fees allowed per patient under the scheme are too low for any doctor to live decently if he turns particular. More than any other group with earned incomes, we doctors are hard-pressed for money in this New Order, you know."

It is all true enough. The days when a good doctor could make his fortune have passed away in Britain. In every country and every age, probably, people have grumbled about doctors' making handsome livings out of other people's afflictions. But when this vague resentment is elevated to the condition of a political dogma, and the doctor is reduced by law to the condition of a minor civil servant, with his remuneration fixed accordingly, regardless of his competence—then the question of rewards and incentives comes gravely to the fore.

LOST STATUS

Most doctors now practicing were trained before the National Health Service came into being, and so must remain in their profession whether they choose or not. But it may not be easy to secure good doctors in the next generation. When the physician and surgeon lose their old status of independence and social dignity, and lose also their once-considerable financial incentive, it may

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be very difficult to attract to the profession people of real competence and real diligence.

Not all doctors, it's true, are worse-rewarded under the National Health Service. A minimum salary is fixed, so that doctors in the out-of-the-way places, where patients are few, may be better off than they were in the old days. The unpopular or less competent doctor, too, may benefit by this leveling process. And the dentist—more by an administrative miscalculation and a backlog of decayed British teeth, perhaps, than by design—is generally better paid than he was before. But by and large the medical profession is now a comparatively depressed calling in Britain.

Nor is the status of the doctor himself the only element to be considered in this problem. The question now is being seriously raised, in sober English journals, whether the general effect of the National Health Service, in the long run, will actually operate to improve the health of the nation.

CROWDING AND ABUSE

Whatever is free tends to be held cheap. Free access to the consulting-room may very well lead to such a crowding and abuse of state medical facilities that the people really in need of medical attention are neglected, necessarily, because they are mixed with a crowd of hypochondriacs, bored old people, and people who insist upon their share of attention simply because they are paying for it through taxes. The recent return to charging — at least nominally — for prescriptions issued under Health Service regulations has reduced such abuses somewhat, but the misuse of medical benefits extends far beyond mere prescription-collecting.

Dr. MacIntosh and physicians like him certainly do not object to decent medical facilities for everyone. Most of them believe that the more prosperous countries of the Western world now can afford a reasonable measure of medical care for everyone. But there are limits to how much any state can afford to spend simply on health-schemes, and the budget of the National Health Service now far exceeds even the most lavish original official estimates of its probable cost.

The question is not one of the desirability of the goal; it is one of means. There are sound reasons for believing that a general improvement of British health might have been better effected by systems of health-insurance, increase of the funds and activities of private and voluntary and cooperative hospitals and medical services, and local—rather than centralized—schemes for improving the health of the poorer people.

OBEDIENCE TO IDEOLOGY

The National Health Service was created out of obedience to socialist ideology, rather than out of any serious examination of the problem and its possible solutions. Indeed, it is a paradox that a vast system of impersonal state charity in medicine has been adopted in Britain precisely at the time when the "poor," in the old sense of that term, have been abolished—at least, the socialists claim they have been abolished.

Many times as much money is spent in Britain on drink, or on football pools, as is spent on private medical attention, and this was true even before the National Health Service was proposed. In the United States, where the public spends a greater proportion of income on medical attention than in any other country, only about 4.5% of family income goes for medical attention. Nearly an equal amount goes for alcoholic beverages, half as much goes for tobacco; and a good deal more goes for recreation. We are living in an age, in short, in which the average man can afford to pay for whatever medical attention he requires, with the exception of the really poor, who are a small minority.

Yet what has been adopted in Britain, and what is sometimes proposed in the United States, is a doctrinaire nineteenth-century solution, socialized medicine, to a problem the terms of which have altered immensely in the twentieth century. In a society of material abundance, state medicine is an obsolete answer.

—*Wall Street Journal*
February 1, 1956.

What Americans Think of the Medical Profession: Report of a Survey

Motivated by a desire to know what Americans really think about their own doctor and physicians in general, the American Medical Association asked a Chicago opinion and market research firm to find out what might be needed to improve doctors' services. The interviewing was done by 289 professional surveyors who talked to 3,000 private citizens, 500 practicing physicians, 100 editors, commentators and columnists, 100 attorneys, 100 registered nurses, 100 registered pharmacists, and 100 non-physician executive secretaries of state and county medical societies. Questions about general public attitudes were asked only of the 3,000 individuals; the professional groups were asked largely about professional and organizational matters.

Two summaries have been compiled from the data. The JOURNAL will publish the results of the survey in three or four instalments.

SUMMARY 1—PART I

AMERICA'S DOCTORS occupy a unique role in modern life. The very nature of their relationships with people is usually most personal and often fraught with emotional factors. Because the doctor officiates at some of the most critical moments in life, it is understandable that individual reactions to doctors are extremely varied. The medical profession, although it numbers only about 220,000, makes an impression upon the public far out of proportion to its numerical size.

What do Americans think about doctors? Are their attitudes toward their own physicians different from their attitudes toward the profession as a whole? If so, why? And, what opinions do doctors themselves hold about other doctors?

To answer such questions the American Medical Association employed an independent research organization, Ben Gaffin Associates of Chicago, to conduct a public opinion poll. Personal interviews were conducted with 3,000 members of the general public, 500 physicians in private practice, and 100 persons in each of five special groups — editors, columnists and commentators; lawyers; pharmacists; registered nurses, and executive secretaries of state and county medical societies. Here are some of the results of that study, along with illustrations based upon figures contained in the full report:

Large percentages of the public say they have a family or personal physician. About five out of six or 82% of the general public indicate they have a personal or family doctor—one whom they usually call first. Farm dwellers report the highest percentage of family doctors (90%) while non-whites indicate the lowest percentage (73%). Westerners and people in medium and large cities also report fewer family doctors than the average.

Just five years ago it was estimated that in one midwestern city* only about half of the population had family doctors. Survey totals indicate that the concentrated efforts by the medical profession to encourage people to secure a personal physician before illness strikes have been quite successful.

Few persons who change family doctors do so because of personality clashes or loss of respect. Although two out of three people who now have family doctors report they have had

Figure 1

I LIKE MY DOCTOR

say	
99%	he's capable
98%	he's intelligent
87%	he's personally interested
81%	he gives me time enough
80%	he's frank with me



other personal physicians in the past, they say that most of the changes of doctors were made because they moved (19%), the doctor moved or entered military service (7%), or the doctor became ill, retired or died (19%). Only small percentages reported they lost confidence in him (5%), found a better doctor (2%), or disagreed with his diagnosis or treatment (1%).

People almost universally like and respect their personal or family physicians. Physicians as individuals were given a vote of confidence by the public. When asked, "Do you like your own doctor as a person?", 96% gave an unequivocal "yes" reply. In other words, 24 out of 25 affirm they like their own doctors. Only one percent said "no" and another one percent gave qualified replies.

Five special professions were surveyed—editors and commentators, lawyers, druggists, nurses, and medical society executive secretaries. Of these special groups, all but the druggists think as highly or even more highly of their doctors than does the general public. About 91%—5% less than the average—of the druggists say they like their own doctor as a person.

People think more highly of their own family doctors than of doctors in general. The high regard people have for their personal physician is clearly shown in their answer to this question: "In what ways, if any, does your doctor seem to be different from most other doctors?" At least 85% say he is different from other doctors. Only one in seven says he is not. His personal interest, sympathy, kindness, competence, intelligence, friendly personality and manner, frankness and honesty are most often cited as the qualities which differentiate him from other doctors. His availability when needed, his patience, understanding, willingness to take enough time with patients, his low fees and his uncomplaining acceptance of payment delays also are mentioned.

Attitudes about doctors are far more favorable than unfavorable. A number of specific questions were asked to determine people's attitudes about physicians. This same set of questions was asked twice, first in regard to "your doctor" and then in regard to "most doctors." Percentages of "true" answers include percentages for those who replied "true" and "probably true" and percentages of "false" replies include both "false" and "probably false" answers. Some of the questions, as shown below, were worded positively:

Do you think—	My Doctor True	Most Doctors True
Doctors are highly intelligent?	98%	93%
Doctors are very capable?	99%	92%
Doctors have enough personal interest in patients?	87%	54%
Doctors are frank enough in talking to patients about their illnesses?	80%	42%
Doctors give patiets as much time as the patients would like?	81%	30%

The public gives high ratings to family doctors and to all doctors on intelligence and capability. (Fig. 1.) While people give their own doctors a similarly high rating on personal interest, frankness, and amount of time spent with patients, their attitudes on these three points toward most doctors are less favorable and show considerable discrepancy. Many questions in the survey about doctors were worded negatively, giving those interviewed the privilege of registering a "true" or "false" reply:

Do you think—	My Doctor True	Most Doctors True
Doctors think they are better than most people?	5%	25%
Doctors have the idea they are always right?	23%	43%
Doctors keep people with appointments waiting longer than necessary?	15%	41%
Doctors are hard to reach for emergency calls?	19%	51%
Doctors are slow to try new drugs and treatments?	7%	11%
Doctors are too quick to recommend an operation?	5%	31%

(Please turn to page 294)

* Milwaukee.

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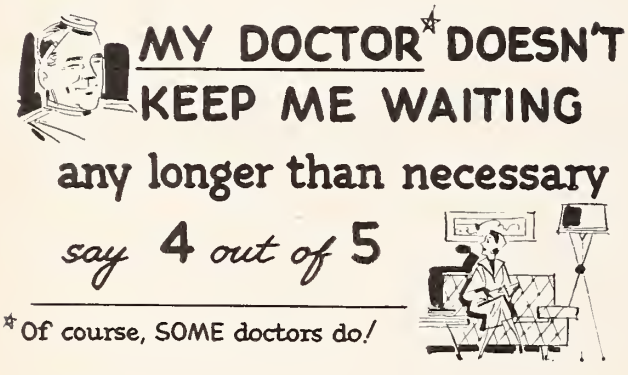
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Doctors are not as dedicated to serving mankind as they should be?---	6%	*27%
Doctors plan to get rich quick?-----	10%	30%
Doctors charge too much? ---------	16%	53%
Doctors' charges have gone up faster than other living costs?----------	13%	35%

Majorities deny most of the frequently voiced complaints about doctors when speaking of their own. For several years the medical profession has been concerned with complaints about long waits in medical offices, refusal to respond to emergency calls, doctors' "know-it-all" attitudes, their tendency to talk in "high-falutin' terms," their cold and impersonal attitudes. Public opinion was surveyed on each of these subjects in the study and when questioned about their own doctors:

78% deny that he keeps patients with appointments waiting longer than is necessary. (Fig. 2.)

Figure 2

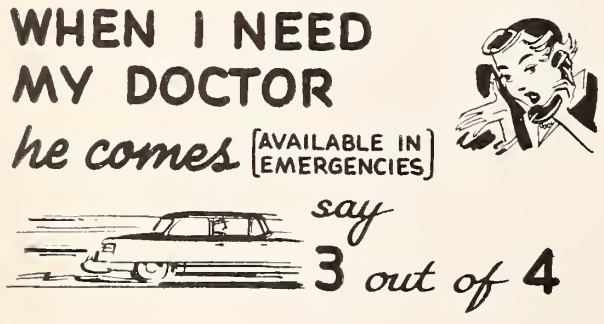


74% deny that he is hard to reach for emergency calls. (Fig. 3.)

91% deny that he thinks he is better than other people.

71% deny that he has the idea he is always right.

Figure 3



* Figure 8.

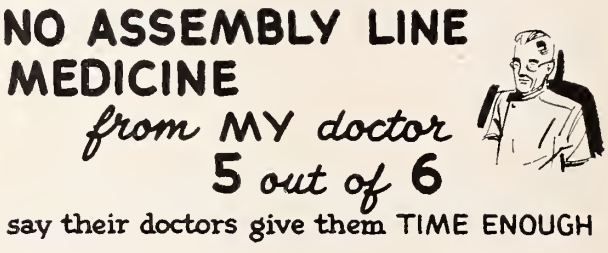
Figure 4



80% deny that he is not frank enough in discussing their illnesses. (Fig. 4.)

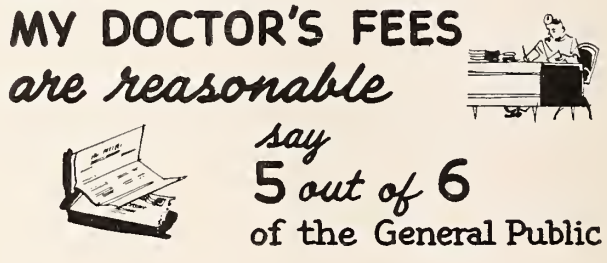
87% deny that he does not take enough personal interest in his patients.

Figure 5



Only about 18% say their own doctors do not give them as much time as they would like (Fig. 5) and 82% deny that he is too quick to recommend an operation. Even on economic questions, the family doctor receives a favorable judgment. Seventy-nine percent deny that he charges too much (Fig. 6), 77% deny that he plans to get rich quick, and 78% deny that his charges have gone up faster than other living costs.

Figure 6



Yet, many people accept certain charges against doctors as a group which they reject for their own physicians. One of the most important revelations of the survey is the evidence that there is a wide divergence between what people feel about their own doctors as contrasted to their feelings toward doctors in general. For example, the survey shows that:

41% of the public say most doctors keep patients with appointments waiting longer than necessary.

(Please turn to page 297)



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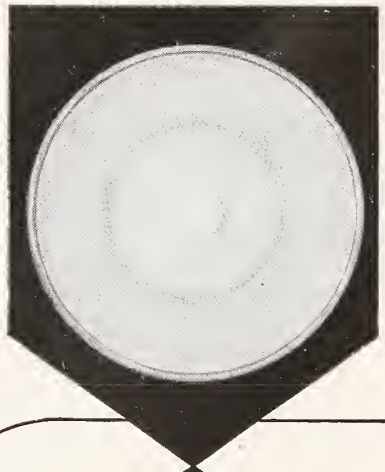
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"MYSTECLIN", "STECLIN" AND "MYCOSTATIN"® ARE SQUIBB TRADEMARKS

51% say most doctors are hard to reach for emergency calls.

25% say most doctors think they are better than other people.

43% say most doctors have the idea they are always right.

46% say most doctors are not frank enough with patients in discussing their illnesses.

Sixty percent of the public say most doctors don't give the patient as much time as the patient would like while only 18% say this is true of their own doctor. About 31% of the public claim that most doctors are too quick to recommend an operation while only 5% say this about family doctors. (Fig. 7.)

Figure 7



MY DOCTOR* OPERATES only when necessary *say* 19 *out of* 20

*But 1 out of 3 thinks OTHER DOCTORS are too quick to operate

Most doctors charge too much, according to 43% of the public, but only 16% say their own doctors do. Thirty-five percent say doctors' charges have gone up faster than other living costs while only 13% say this about their own physician's charges. And 30% of the public believe most doctors plan to get rich quick, while this belief is held by only 10% in regard to their own doctors. (Fig. 8.)

Yet it is often those individuals without family or personal physicians who register criticisms about doctors. People without family doctors most frequently say (57%) that doctors are not frank enough in talking to patients about illnesses. They are also more critical of doctors' lack of personal interest (46%). Quite naturally, this group also complains most frequently (50%) about waiting too long in doctors' offices and accuses doctors (53%) of believing in their own infallibility. These figures emphasize the importance of establishment of a family physician relationship.

The public cites a number of qualities in most doctors which they like. Doctors in general are

Figure 8



Only One person in 8 thinks his doctor's CHARGES have gone up too fast

Only One in 10 thinks his doctor plans to GET RICH QUICK

Only One in 17 thinks his doctor is NOT DEDICATED enough

liked most for their friendly personalities, sympathy and competence. When asked, "What do you like about most doctors?", 30% say they like their friendly personalities and manner and 19% mention their personal interest in people, their sympathy and kindness. Their competence and intelligence are cited by 18% and 13% mention their healing and curing abilities. Another 13% say they like doctors because they are sincere, dedicated, and try to help patients. Their frankness, honesty, patience and understanding are also given as reasons for liking them. Only 2% say they don't like anything about physicians.

"What do you like about most doctors?"

Friendly, personality, manner	30%
Personal interest, sympathy, kindness	19
Competent, intelligent, educated	18
Heal you, cure you	13
Sincere, dedicated, try to help	13
Frank, honest	10
Patient, understanding	4
Available, come when called	3
Take time, do not rush you	2
Service	1
Professional attitude	1
Reasonable fees, fair charges	1
Miscellaneous likes	3
Nothing, don't like them	2
Don't know	11

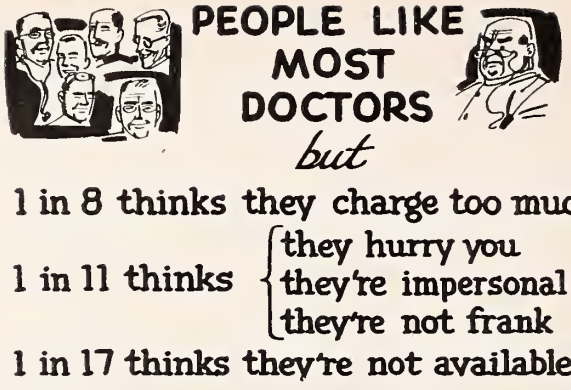
Only 55% of the public listed specific criticisms in regard to doctors. Some of these per-

sons complain not about "most" doctors but about "some" doctors. (Fig. 9.) Those who were interviewed were also given the opportunity to criticize physicians. Only 55% of the public state any dislikes and some complain not about "most" doctors but about "some" doctors. Fees, hurrying patients, coldness and lack of frankness are the criticisms most often given. However, not even these evoke much disapproval:

"What don't you like so well about most doctors?"

Their charges, interest in money	13%
Don't take time, hurry you too much	9
Impersonal, cold, independent	9
Not frank, speak half-truths, dishonest	9
Unavailable, won't come, can't be reached	6
Conceited, sarcastic	4
Incompetent, poor diagnoses, mistakes	4
Keep patients waiting too long	2
Give too many shots, too quick to operate	1
Bad tempered, crabby	1
Other dislikes	6
Nothing, like them	30
Don't know	15

Figure 9



Since people apparently feel more favorably inclined toward their own doctors than toward most doctors, it is not the public relations of the individual physician which requires increased attention, but the public relations of the medical profession as a whole. One conclusion can, however, be drawn from public reactions. *People's attitudes toward their own doctors are based upon their own personal experiences, while their attitudes toward doctors in general must necessarily be based upon secondary information and hearsay.*

NOTE: Part II of the first summary of the survey will be published in the April issue of The JOURNAL. Doctors' views about doctors, the question of overspecialization, and some recommendations for doctors are included in that portion of the report.

The saga of bringing medical training in the United States to world leadership in 40 startling years of progress is one of the dramatic episodes of our time. To these medical schools we owe a debt of gratitude for helping make America the healthiest and most prosperous nation in the world. Salute them during Medical Education Week.



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Programs Complete for I.U. Courses on Anemia, Trauma and Radioisotopes

A POSTGRADUATE CLASS limited to 30 physicians will be held at 1:30 p.m. (EST) April 11 in the Medical School Auditorium at I. U. Medical Center with speakers discussing "The Anemias." A $10 registration fee should be sent to the Postgraduate Office, I. U. School of Medicine, 1100 West Michigan St., Indianapolis 7, Indiana. This also covers cost of the dinner.

The program follows:

1. Relationship of behavior disturbance to inadequate iron intake in babies and children.	Lyman T. Meiks, M.D.
2. Iron deficiency anemias and polycythemia rubra vera.	Paul J. Fouts, M.D.
3. Recognition and treatment of erythroblastosis.	William Segar, M.D.
4. Macrocytic anemias.	Paul J. Fouts, M.D.
5. Hemoglobinopathies.	William H. Bond, M.D.
6. Anemias encountered in the surgical patient.	Harold King, M.D.
7. Anemias in Gynecology and Obstetrics.	Carl P. Huber M.D.
8. Anemias of neoplastic diseases.	William H. Bond, M.D.
9. Hemolytic anemias.	Robert J. Rohn, M.D.

4:30 p.m.—ROUND TABLE—Medical School Auditorium.

6:00 p.m.—DINNER—Student Union Building.

A brief discussion period will follow each paper.

ACUTE SURGICAL EMERGENCIES

An afternoon and evening postgraduate course in Trauma will be presented at I. U. School of Medicine on April 18. The program follows:

EST	
1:00 Blunt trauma to the abdomen	Dr. Harold King
1:40 Penetrating abdominal injuries	Dr. Frederic Taylor
2:20 Spinal cord injuries	Dr. L. W. Freeman
3:00 Intracranial trauma	Dr. John Russel
3:50 Urologic injuries	Dr. Robert Garrett
4:30 Fluid and electrolyte balance in the oliguric patient	Dr. G. T. Lukemeyer
Dinner recess 5:00 to 7:00 p.m.	
7:00 Cardiovascular injuries	Dr. H. B. Shumacker, Jr.
7:45 Chest injuries	Dr. Stanley Battersby
8:30 Round table discussion and question and answer period	Faculty

RADIOISOTOPES

Programs for the next three weekly postgraduate courses in clinical uses of radioisotopes follow:

MARCH 21

1. Evaluation of Methods of Measuring the Accumulation of I-131 by the Thyroid Gland	Dr. John P. Storaasli, Portsmouth, Va.
2. Tracer Studies on Body Fluids	Dr. Storaasli
3. Tumor Localization Procedures with Radioisotopes	Dr. Kenneth Corrigan, Detroit
4. Demonstrations	I. U. Staff

APRIL 4

1. Any Postponed Presentation from Previous Weeks
2. Special Movies on Isotopes
3. Laboratory Exercises for Participants
4. Discussion of Procurement and Allocations of Radioisotopes by AEC Representative

APRIL 11

1. Treatment of Hyperthyroidism with I-131 (2 hours)	Dr. D. E. Clark, Chicago
2. Treatment of Euthyroid, Cardiac and Thyro-Cardiac Disease	I. U. Staff
3. Carcinoma of the Thyroid Gland with I-131	Dr. Clark

Deaths . . .

Charles W. Comer, M.D., 40, Mooresville physician and surgeon, died January 11 in St. Vincent's Hospital, Indianapolis. He had been ill for more than a year.

Doctor Comer was born in Johnson County but had lived in Mooresville since he was a small child. He was graduated from Indiana University School of Medicine in 1939. He had been associated since then with his father, the late Dr. Jonathan Comer, and his brother, Dr. Kenneth Comer, in the operation of the Comer Sanitarium in Mooresville. During World War II Doctor Comer served as a first lieutenant in the Army Medical Corps for two years.

He had been active in the Morgan County Medical Society, having served as president. He was also a member of the Indiana State and American Medical Associations.

Charles Edward Stone, M.D., Bedford otolaryngologist for more than 35 years, died February 11. He was 76.

Doctor Stone received his medical degree from Kentucky University Medical Department at Louisville in 1904. He practiced for a number of years in Idaho and Colorado.

Doctor Stone was a senior member of Lawrence County Medical Society and the Indiana State Medical Association. He also was a member of the American Medical Association.

Will Warren Washburn, M.D., 55, died in St. Elizabeth Hospital, Lafayette, February 10. He was a practicing urologist in Lafayette for many years.

Doctor Washburn was born in Remington. He received his degree in medicine from Indiana University School of Medicine in 1925.

During World War II he served for five years as a flight surgeon with the U. S. Air Corps.

Doctor Washburn had been active in affairs of the Tippecanoe County Medical Society. He was a past president and a member of many society committees. He had also been active in the Indiana State Medical Association and was serving this year as chairman of the Committee on School Health and Physical Education. He had also been a delegate to I.S.M.A. in 1953.

Other affiliations included the American Urological Association and the American Medical Association.

Doctor: Your wife will enjoy this program.

83rd ANNUAL MEETING, THURSDAY, APRIL 12, 1956

NORTHERN TRI-STATE MEDICAL ASSOCIATION

RACKHAM AUDITORIUM, ANN ARBOR, MICHIGAN

ANNUAL EDUCATIONAL ASSEMBLY PROGRAM

A.M. 8:00 **REGISTRATION** (Eastern Standard Time)

8:55 **INTRODUCTORY REMARKS**
Dr. C. Howard Ross, President, Northern Tri-State Medical Association

9:00 **WELCOME**
Dr. L. Dell Henry, President, Washtenaw County Medical Society

9:10 **PANEL DISCUSSIONS** (First listed serves as Moderator)
"MEDICAL EDUCATION OF TOMORROW"
Dr. Harlan Hatcher, President, University of Michigan
Dr. Clarence Hilberry, President, Wayne University
Dr. A. C. Furstenberg, Dean, University of Michigan Medical School
Dr. Gordon Scott, Dean, Wayne University Medical School

9:50 *"COMMON GYNECOLOGICAL ERRORS"*
Dr. H. H. Cummings, Gynecologist, St. Joseph Hospital, Ann Arbor
Dr. Norman Miller, Chief, Obstetrics and Gynecology, University Hospital
Dr. Norman Banghart, Department of Obstetrics and Gynecology, St. Joseph Hospital
Dr. Ward Seeley, Professor, Obstetrics and Gynecology, Wayne University
Dr. Richard Stander, Instructor, Obstetrics and Gynecology, University Hospital

10:30 CYRUS C. STURGIS PANEL: *"THE GERIATRIC LUNG"*
Dr. Winthrop N. Davey, Director, Tuberculosis Unit, University Hospital
Dr. Herbert Sloan, Associate Professor, Thoracic Surgery, University Hospital
Dr. D. W. Martin, Physician, Beyer Memorial Hospital, Ypsilanti
Dr. Carl Frye, Physician, St. Joseph Hospital

11:10 *"THE DOCTOR AS A WITNESS"*
Mr. Jack Pickering, Medical Reporter, Detroit Times
Dr. S. W. Donaldson, Director of Radiology, St. Joseph Hospital
Dr. Bernhard Steinberg, Director, Institute of Medical Research, Toledo, O.
Dr. Oliver W. Lohr, Director, Central Laboratories, Saginaw, Mich.
Mr. Clayton C. Purdy, Attorney, Detroit, Michigan, Essayist

11:50 *"THE HYPOTENSIVES—THEIR STRENGTH AND PITFALLS IN THERAPY"*
Dr. Sibley Hoopler, Director, Hypertension Unit, University Hospital

P.M. 12:10 **LUNCHEON:** Michigan League Ballroom—Wives Cordially Invited

a. Short business meeting

b. STYLE SHOW—Under the auspices of the Collins Shoppe and Washtenaw County Medical Auxiliary, with kind acknowledgments to Mrs. Henry R. Scovill and Mrs. Charles Newton.

c. ADDRESS

"GREATEST PROBLEM FACING AMERICAN MEDICINE"
by
DR. JOHN S. DETAR, Milan, Michigan
National President, American Academy of General Practice

1:50 Intermission before Afternoon Session

2:00 **PANEL DISCUSSIONS**
"THE SALK VACCINE AFTER ONE YEAR"
Dr. Thomas Francis, Jr., Professor, Chairman, Dept. of Epidemiology, School of Public Health
Dr. F. M. Hemphill, Associate Professor, Public Health Statistics, School of Public Health
Dr. John Porterfield, Director, State Department of Mental Health and Correction, Columbus, Ohio
Dr. Otto K. Engelke, Washtenaw County Health Director

2:40 FREDERICK A. COLLER PANEL: *"THE ACUTE ABDOMEN"*
Dr. Robert Berry, Professor of Surgery, University Hospital
Dr. Thurston Thieme, Surgeon, St. Joseph Hospital
Dr. Clarence Crook, Surgeon, St. Joseph Hospital
Dr. Lyndon Lee, Jr., Director of Surgery, Wayne County General Hospital

3:20 JAMES L. WILSON PANEL: *"PEDIATRIC NEUROLOGY"*
Dr. Russell DeJong, Chief, Neurology, University Hospital
Dr. William Noshay, Chief, Neurology, Henry Ford Hospital
Dr. Harry Towsley, Professor of Pediatrics, University Hospital
Dr. Aaron Edwards, Pediatrician, St. Joseph Hospital

4:00 MARK MARSHALL PANEL: *"THYROID GLAND, NORMAL FUNCTION AND PATHOLOGY"*
Dr. Darrell Campbell, Surgeon, St. Joseph Hospital
Dr. S. E. Gould, Pathologist-in-Chief, Wayne County General Hospital
Dr. B. C. Payne, Internist, St. Joseph Hospital
Dr. W. H. Beierwaltes, Internist-Isotopist, University Hospital
Dr. T. P. Eberhard, Radiologist-Isotopist, St. Joseph Hospital

4:40 **CONFERRING OF DISTINGUISHED MEDICAL CITIZENSHIP AWARD**
Dr. John M. Sheldon, Director, Department of Post-Graduate Medicine, University of Michigan, will present this award to Dr. Howard H. Cummings, Professor Emeritus, Post-Graduate Medical Education.

5:00 INTERMISSION

5:45 COCKTAILS—Allenel Hotel

7:00 DINNER AND MEETING OF THE WASHTENAW COUNTY MEDICAL SOCIETY, CANCER PROGRAM —Allenel Hotel

EVENING FOR THE LADIES

For further information write: Dr. James E. Bailey, Secretary
Northern Tri-State Post-Graduate Medical Association
292 East Chicago Street Coldwater, Michigan

NEWS NOTES—from State and Nation

Sheridan Doctor Named "Citizen of the Year"

Dr. John L. Reck who has served as physician and surgeon in Sheridan for 46 years was awarded the 1955 Sheridan Rotary Club Award for outstanding citizenship on January 24 at a meeting in the Community Center.

Dr. Reck, the oldest practicing physician in Sheridan, is a native of Ohio. He was graduated from the Indiana University School of Medicine in 1908 and established his practice that year in Sheridan where he has delivered 3,000 babies, and served many families in the area. He has been active in many civic undertakings including his lodge affiliations.

Dr. Reck is a member of Hamilton County Medical Society, the Indiana State and American Medical Associations.

The award of the walnut plaque was made by Robert Dillinger of the Rotary Club.

The American Journal of Digestive Diseases, which has been published since its founding in Fort Wayne, has been sold to Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, New York. The January edition appeared in new format under the supervision of a new editorial board. Editors are Dr. Henry Janowitz, head of the Department of Gastroenterology, Mt. Sinai Hospital, New York, and Dr. Maxwell H. Poppel, head of radiology at Bellevue Hospital, New York. A seven-man editorial board assists them. New address of the publication is 49 East 33rd Street, New York 16, New York.

Dr. R. S. Carpenter, who entered the practice of medicine in Orland recently, is expanding his practice to include the Hudson area where he has established an office. Dr. Carpenter was gradu-

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Erythromycin in treatment of pyoderma*

8/12/55

DISCHARGE SUMMARY

Patient, white female, age 39, entered hospital with a diagnosis of lymphoma, proved to be lymphosarcoma by biopsy.

Initially she was treated by X-ray radiation, adrenal cortical hormone and an antinauseant. During this regimen she developed a generalized rash which became infected. This was a drug reaction with infection due either to (1) scratching or (2) a low WBC count due to radiation. A number of boil-like lesions appeared over the body.

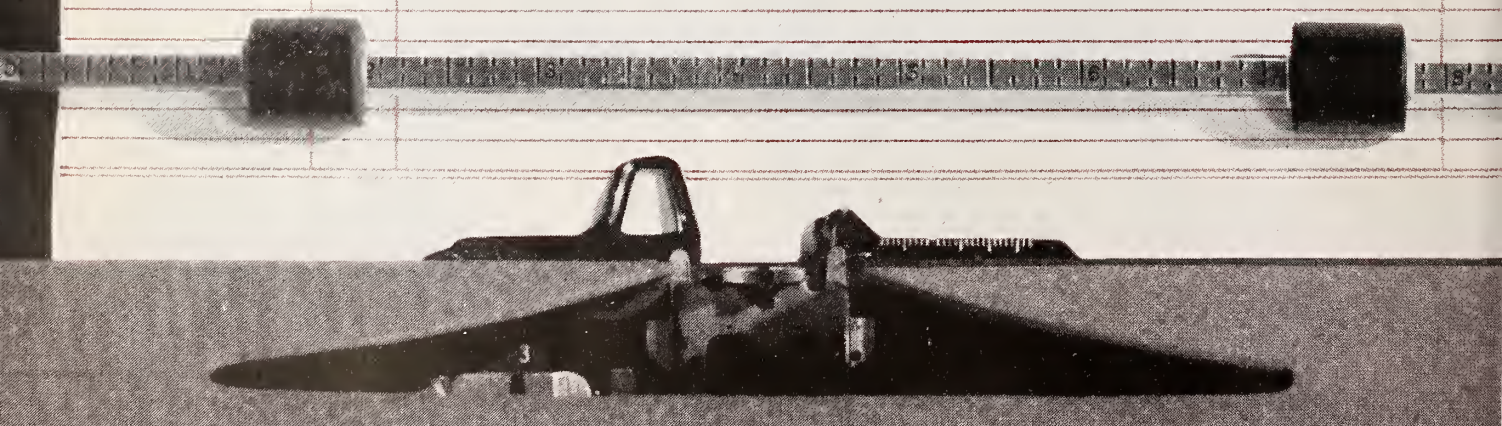
On 8/4 penicillin was started in a dosage of 600,000 units daily. Penicillin was continued for six days during which time the pyoderma became worse.

Aspirated material from the lesions yielded hem. S. aureus, coag. + and the following sensitivities were obtained: penicillin, more than 10 units; erythromycin, 10 mcg.; tetracycline, 50 mcg. When these results became available penicillin was discontinued.

On 8/9, erythromycin was started in a dosage of 200 mgm. q.i.d. Marked improvement was noted very soon and by 8/12 almost complete healing of all lesions had occurred. Patient was afebrile throughout.

Final Diagnosis: (1) lymphosarcoma (2) secondary pyoderma due to hemolytic Staphylococcus aureus.

Result: complete healing of secondary pyoderma with erythromycin.



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ated in medicine from the University of Benares, India, in 1944 and interned at the American Methodist Hospital in Bombay. He took his master's degree in surgery at the University of Michigan and then spent a year in England and Scotland taking special training in ear, nose and throat surgery. He was resident surgeon at Cooper Hospital, Camden, New Jersey for two years, and was on the surgical staff of St. John's Hospital, New Brunswick for a year.

Stepped-Up Promotions Announced For Army Medical Officers

Under revised promotion policies, physicians will be eligible for temporary promotion to the grade of major, lieutenant colonel and colonel one year sooner than other Army officers, it has been announced by Major General Silas B. Hays, the Army Surgeon General.

As a result of the policy, it is estimated that 390 medical officers will be promoted to higher grades during the period ending June 30, 1956.

Consideration is also being given to more rapid promotion of lieutenants to the grade of captain.

The action gives additional recognition to the long and expensive training required of doctors before they can qualify for Army commissions. It was pointed out that these officers have at least nine years of training beyond the high school level while most other Army officers have less formal education at the time they are commissioned.

With the majority of Army medical officers now serving temporary two-year periods as a result of the Doctor Draft Act, accelerated promotions are another means of attracting career officers into the Army.

Dr. William C. Schaefer, psychiatrist at St. Mary's Hospital, Evansville, has joined the staff of Henry Ford General Hospital, Detroit, where he will be an associate in the physical medicine and rehabilitation department. Dr. Schaefer had been in Evansville since 1950, except for two years during which he served residencies in psychiatry.

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way in x-ray
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point the needle to the measured thickness of that part in the patient you're x-raying.

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that's all there is to it. "Dial-the-part" automation takes it easy, gets it right every time.

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Terre Haute Doctors Plan New Medical Center

Articles of incorporation have been filed in Vigo County for the Medicenter to be constructed at Thirtieth and Poplar streets, Terre Haute. Work is to start April 1.

Directors of the corporation are Drs. Stuart R. Combs, Malachi C. Topping, Robert N. Kabel, Paul J. Bronson and Roy J. Ault.

The modern office building for physicians is expected to be ready for occupancy by fall.

Dr. Harold L. Taylor has been named to head Pitman-Moore Company's immuno-chemistry department, it has been announced by Dr. S. R. Bozeman, director of the firm's biological laboratories. For the last 10 years, Dr. Taylor has been biochemist in charge of human plasma fractionation and plasma research for the Michigan Health Department. He is a native of Oklahoma and received his degree in chemistry and physiology from the University of Kansas.

Dr. Kenneth L. Craft, Indianapolis, will present a paper on "Treatment of Sinusitis" at the June 12-14 convention of American Medical Association in Chicago.

Dystrophic Strain of Mice To Be Studied Under Grant

Announcement has been made by the Muscular Dystrophy Associations of approval of a research grant for approximately $50,000 to Jackson Memorial Laboratory, Bar Harbor, Maine, for continued study of a dystrophic strain of mice.

Under the MDAA grant, William S. Murray, Sc.D., administrative director of Jackson Memorial Laboratory, will direct a staff of assistants in studies involving "The genetic mutant of muscular dystrophy in mice and the production and development of muscular dystrophy mice for research at other laboratories".

The grant is in keeping with MDAA's program of sponsoring, through generous public support, significant research in the quest for the cause and a cure for muscular dystrophy.

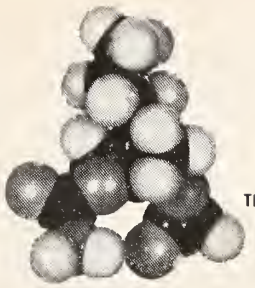
Clinical Reviews

MAYO CLINIC AND MAYO FOUNDATION
APRIL 9, 10 AND 11, 1956
ROCHESTER, MINNESOTA

This 3-day program will be devoted to lectures and discussions on problems of current interest in general medicine and surgery. The presentations will be made by staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota.

There are no fees of any kind.



THE MILTOWN MOLECULE

Two articles in the April 30th issue of The Journal of the AMA[1,2] report on . . .

an entirely new type of tranquilizer with muscle relaxant action—orally effective in

ANXIETY, TENSION and MENTAL STRESS

- no autonomic side effects—well tolerated
- selectively affects the thalamus
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- not habit forming, effective within 30 minutes for a period of 6 hours
- supplied in 400 mg. tablets. Usual dose: 1 or 2 tablets—3 times a day

1. Selling, L. S.: J.A.M.A. **157:** 1594, 1955. **2.** Borrus, J. C.: J.A.M.A. **157:** 1596, 1955.

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HOME LAWN MINERAL SPRINGS
M. C. PITKIN, M.D., *Medical Director*
J. W. GIBBS, M.D., *Associate*

THE MARTINSVILLE MINERAL SPRINGS
RAY D. MILLER, M.D., *Medical Director*

DONALD H. KENNEDY, *Executive Director*

Dr. Lowell Coggeshall Named to Special Post in HEW Department

Dr. Lowell T. Coggeshall, Dean of the Division of Biological Sciences and the School of Medicine at the University of Chicago, has been approved by the United States Senate as Special Assistant for Health in the Department of Health, Education and Welfare. He had been named to the post by President Eisenhower at the request of Marion Folsom, Secretary of Health, Education and Welfare.

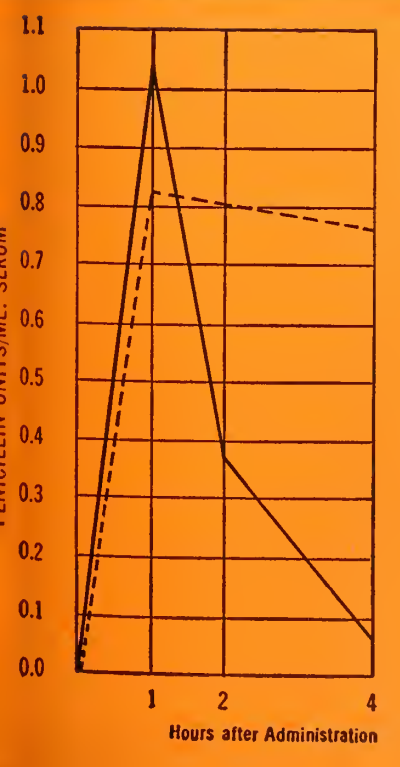
Dr. Coggeshall, who has been Dean at the University of Chicago since 1947 first served there in 1928 as intern after getting his degree of Doctor of Medicine from Indiana University that same year. He later was made assistant professor of medicine. In 1935 he went to the International Health Division, Rockefeller Institute, Rockefeller Foundation, New York City, to do research in tropical diseases.

In 1940 he became professor of preventive medicine at the School of Public Health, University of Michigan. He was chairman of the Department of Tropical Disease from 1942 to 1944. He joined the Medical Corps of the U. S. Navy in January 1944 leaving the service with the rank of Captain. He was made chairman of the Department of Medicine of the U. of Chicago in 1946.

Dr. Robert L. Simpson, Bluffton physician and surgeon, left January 21 for Canton, Ohio where he and Mrs. Simpson were honored by the Canton Methodist church which has joined the Bluffton Methodist church in sponsoring Dr. and Mrs. Simpson in missionary work. Dr. and Mrs. Simpson are now in Hartford, Connecticut attending the Kennedy School of Missions. On completion of their course in June they will return to Indiana briefly and then leave for Africa.

Dr. William Wood, clinical director of Norways Foundation Hospital, Indianapolis, recently addressed two sectional meetings of the American Protestant Hospital Association in St. Louis. He spoke to the chaplains and the hospital administrators groups.

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—— PEN·VEE·*Suspension*, 300,000 units

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*Lawrence, W. E.; Kahn, S. S., and Riser, A. B.: South. M. J. 47:105, 1954.

98656

Kentucky Pediatric Society Announces Annual Meeting

The annual scientific meeting of the Kentucky Pediatric Society will be held April 5 at the Brown Hotel, Louisville.

Dr. Horace L. Hodes, clinical professor of pediatrics, Columbia University, College of Physicians and Surgeons, and chief of pediatrics, The Mount Sinai Hospital, New York City, will address the group at 3:30 p.m. and 7:45 p.m. The topics of his discussion will be: "The Etiology and Control of Infantile Diarrhea" and "APC Virus Diseases."

A cocktail hour will follow the business meeting and the banquet is at 6:30 p.m. Members who wish to bring guests should make arrangements by writing to Dr. Selby V. Love, Secretary, 226 East Chestnut Street, Louisville 2, Kentucky.

Dr. Robert Flanders, a specialist in internal medicine, is now associated with the Memorial Clinic, Indianapolis. Dr. Flanders is a 1949 graduate of Harvard Medical School and a veteran of two years service in the Navy. He formerly lived in Manchester, New Hampshire, where his father is a physician. Dr. Flanders is a son-in-law of Dr. Frank Gastineau, Indianapolis.

Drs. R. Fred Broach and **Mannfredo R. S. Yanson** have recently become affiliated with the Caylor-Nickel Clinic, Bluffton. Dr. Broach is serving a residency in radiology, and Dr. Yanson a four year residency in surgery.

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Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

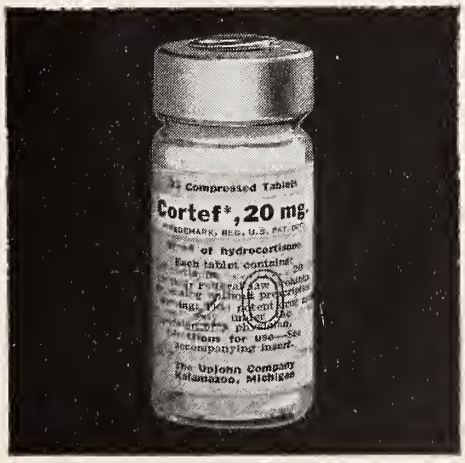
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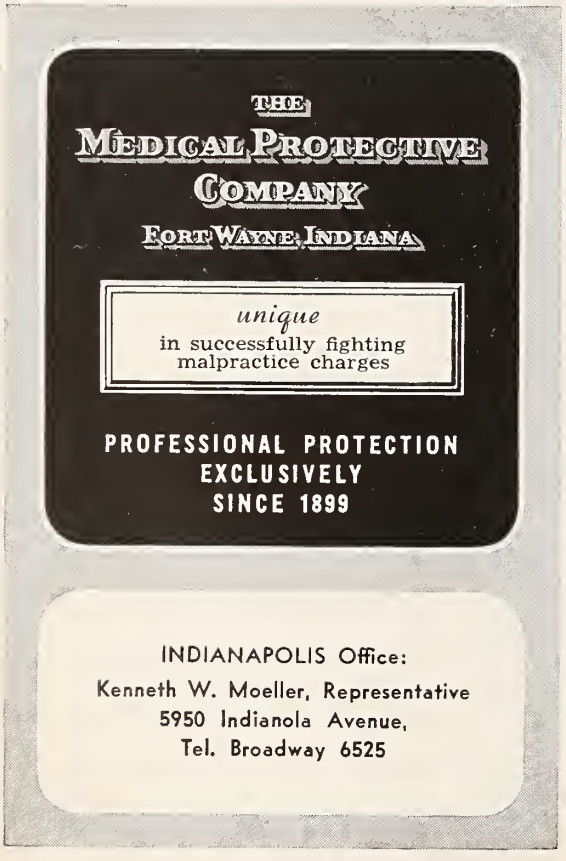
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Dr. Claude S. Beck to Lecture at Medical Center

"Operations for Coronary Artery Disease" will be discussed by Dr. Claude S. Beck, Department of Surgery, Western Reserve University, Cleveland, on March 29 at the Medical School Auditorium at Indiana University Medical Center. Dr. Beck will use both film and slides to illustrate his talk. He will speak at 8 p.m.

The event is being sponsored by Pi chapter of Phi Rho Sigma fraternity. Robert Costin and Erwin Gutowitz are co-chairmen in charge of arrangements.

There is no fee and no reservations are required. The meeting is open to all physicians.

National Conference on Rural Health Scheduled

The 11th National Conference on Rural Health, featuring the theme, "Your Doctor and You", is being held at the Multnomah Hotel, Portland, Oregon, March 8-10.

Dr. F. S. Crockett, Lafayette, co-founder of the AMA's Council on Rural Health, delivers the keynote speech on this topic on March 8. He also was scheduled to preside at the annual banquet on March 9.

Dr. Joseph E. Dudding, Hope, chairman of the I.S.M.A. Committee on Rural Health, is the official representative of the State Association at the meeting.

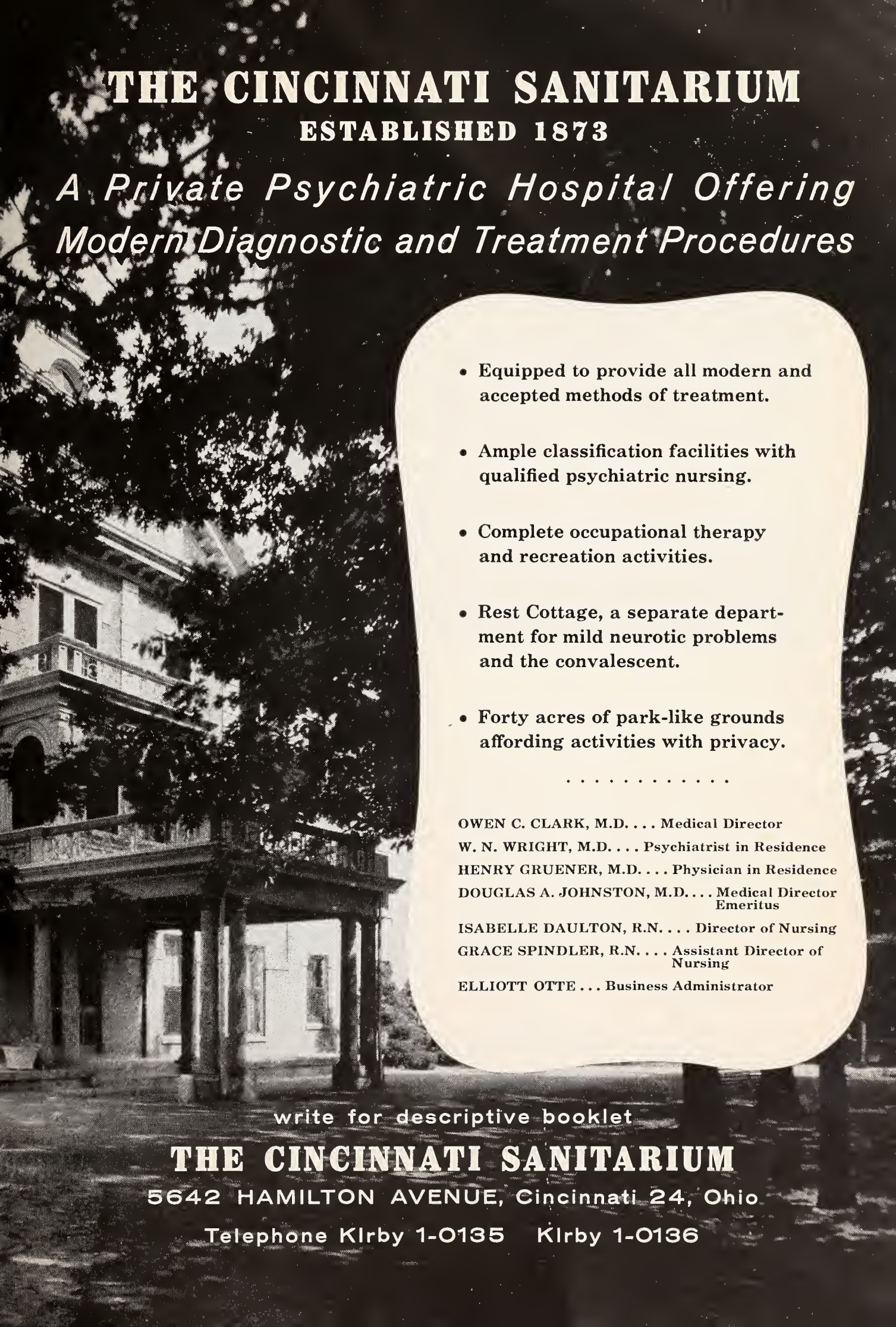
Dr. Philip B. Reed, Indianapolis, attended an executive committee meeting of the Central Inspection Board, American Psychiatric Association on January 19 in Washington, D. C. The group considered a draft of the manual to be used for inspection of private mental hospitals.

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DOUGLAS A. JOHNSTON, M.D. . . . Medical Director Emeritus

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

The Council

January 15, 1956

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:00 a.m., Sunday, January 15, 1956, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Kenneth L. Olson, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Represented by William B. Challman, Mt. Vernon
Second District—Sam I. Rotman, Jasonville, alternate
Third District—Keith Hammond, Paoli; John M. Paris, New Albany, alternate
Fourth District—J. E. Dudding, Hope
Fifth District—M. C. Topping, Terre Haute; V. Earle Wiseman, Greencastle, alternate
Sixth District—Harry P. Ross, Richmond; William R. Tindall, Shelbyville, alternate
Seventh District—Lester D. Bibler, Indianapolis; Charles A. Jones, Franklin, alternate
Eighth District—Guy A. Owsley, Hartford City; Gordon B. Wilder, Anderson, alternate
Ninth District—Wemple Dodds, Crawfordsville; H. E. Klepinger, Lafayette, alternate
Tenth District—James P. Vye, Gary; Ralph C. Eades, Gary, alternate
Eleventh District—Max R. Adams, Flora
Twelfth District—Maurice E. Glock, Fort Wayne
Thirteenth District—Kenneth L. Olson, South Bend

Officers:

Walter U. Kennedy, New Castle, president
O. W. Sicks, Indianapolis, treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor
A. W. Cavins, Terre Haute, associate editor

Executive Committee:

James W. Denny, Indianapolis, chairman
E. H. Clauser, Muncie
Albert Stump, attorney
Robert Hollowell, attorney
Robert J. Amick, field secretary
Kenneth W. Bush, field secretary
J. A. Waggener, executive secretary

Guests:

Cleon A. Nafe, Indianapolis, A.M.A. delegate
James M. Leffel, Indianapolis, chairman, Committee on Convention Arrangements
Jack E. Pilcher, Indianapolis, chairman, Committee on Scientific Work
J. L. Arbogast, Indianapolis, chairman, Committee on Scientific Exhibits
Norman R. Booher, Indianapolis, president, State Welfare Board
Frank Green, Rushville, president, Indiana Academy of General Practice
James W. Crain, Williamsport, chairman, Committee on Veterans' Affairs and Rehabilitation
Earl W. Mericle, Indianapolis, chairman, Committee on Public Relations
A. C. Offutt, Indianapolis, secretary, State Board of Health
Kenneth O. Neumann, Lafayette, Tippecanoe County Health Officer
Joseph E. Palmer, Indianapolis, executive secretary, Indianapolis Medical Society

On motion of Drs. Glock and Bibler, the minutes of the meetings of the Council held at French Lick on October 16 and 19, 1955, were approved as printed in the December, 1955, issue of THE JOURNAL.

COUNCIL REFERENCE COMMITTEE

The chairman announced the appointment of the following Council reference committees for 1956:

Journal:
M. C. Topping, chairman; Guy A. Owsley, Harry P. Ross

Legislation:
Minor Miller, chairman; J. H. Crowder, Wemple Dodds

Insurance:
Lester D. Bibler, chairman; Guy A. Owsley, Max R. Adams

Constitution and Bylaws:
Harry P. Ross, chairman; J. P. Vye, M. C. Topping

Medical Education:
Maurice E. Glock, chairman; J. E. Dudding, Wemple Dodds

Public Health:
J. E. Dudding, chairman; Minor Miller, Keith Hammond

Physician-Hospitals:
J. H. Crowder, chairman; Lester D. Bibler, Maurice E. Glock

REPORTS OF COUNCILORS

The councilors reported 1956 district meetings scheduled as follows:

First District—Mt. Vernon, September 20, 1956
Second District—Washington, _____, 1956
Third District—French Lick, May_____, 1956
Fourth District—Aurora, May 2, 1956 (tentative)
Fifth District—Greencastle, June 6, 1956
Sixth District—Richmond, _____, 1956
Seventh District—Indianapolis, May 8, 1956
Eighth District—Anderson, May 9, 1956
Ninth District—Frankfort, May 24, 1956
Tenth District— _____
Eleventh District—Delphi, May 16, 1956
Twelfth District—Fort Wayne, May 16, 1956
Thirteenth District—South Bend, November 14, 1956

REPORTS OF OFFICERS

Dr. Walter U. Kennedy, president: "I want to express an appreciation of the very great activity of the committees that have been appointed. It is exceedingly gratifying to see how well they have taken up their work and are attempting to produce something useful to the medical profession, and I deeply appreciate it.

"My trip to Europe was curtailed very suddenly, but I will make some observations which will be

printed later and distributed among you." (Dr. Kennedy spoke briefly about his trip.)

Dr. O. W. Sicks, treasurer, presented the following report, compiled by George S. Olive and Company, certified public accountants, which shows the association in good financial condition. He called attention to the increase of $20,377.27 in assets in 1955. General Fund investments total $211,000.00 and Medical Defense Fund investments $17,000.00, with anticipated interest income of $6,390.10 in 1956. On December 31, 1955, the total of all assets of the association, as shown by the auditor's report, was $258,426.29.

January 11, 1956

The Council,
Indiana State Medical Association,
Indianapolis, Indiana.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1955, and the statements of income and expense and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds and related statements of income and expense, on a cash receipts and disbursements basis, present fairly the position of the Indiana State Medical Association at December 31, 1955, and the results of its operations for the year then ended, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Yours very truly,

GEO. S. OLIVE & CO.,
Certified Public Accountants.

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION
Analysis of Increase in Assets, All Funds
Year Ended December 31, 1955

TOTAL ASSETS, DECEMBER 31, 1955—exhibit B		**$258,426.29**
TOTAL ASSETS, JANUARY 1, 1955		**238,049.02**
NET INCREASE		**$ 20,377.27**
Arising from the following sources:		
Excess of operating cash receipts over operating cash disbursements, year ended December 31, 1955:		
General fund—exhibit C:		
Receipts	$121,696.00	
Disbursements	100,609.21	
		$ 21,086.79
The Journal of the Indiana State Medical Association—exhibit D:		
Receipts	52,126.79	
Disbursements	51,273.14	
		853.65
Medical Defense Fund—exhibit E:		
Receipts	4,966.36	
Disbursements	6,529.53	
		(1,563.17)
NET INCREASE		**$ 20,377.27**

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION

Statement of Assets, All Funds,
at December 31, 1955

GENERAL FUND:			
Cash on deposit—exhibit C		$ 13,497.53	
Petty cash fund		1,500.00	
Investments:			
U. S. Treasury bonds	$115,000.00		
U. S. Saving bonds	96,000.00		
		211,000.00	
		225,997.53	
Deduct: Due to Medical Defense fund		25.00	
Total general fund			$225,972.53
THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:			
Cash on deposit—exhibit D			6,932.62
MEDICAL DEFENSE FUND:			
Cash on deposit—exhibit E		8,496.14	
Investments:			
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	12,000.00		
		17,000.00	
Add: Due from general fund		25.00	
Total Medical Defense fund			25,521.14
TOTAL ASSETS, ALL FUNDS—exhibit A			**$258,426.29**

What makes Viceroy different from other filter cigarettes?



The VICEROY filter tip contains 20,000 tiny filters made exclusively from pure cellulose . . . soft, snow-white, natural. This is twice as many filters as the other two largest-selling filter brands.

That is why VICEROY gives you such a fresh, clean taste—that real tobacco taste you miss in other filter brands. No wonder so many doctors now smoke and recommend King-Size VICEROYS.

If it's Viceroy you can tell the difference blindfolded!



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Exhibit C

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1955, and December 31, 1954

GENERAL FUND

	Year Ended Dec. 31, 1955	Dec. 31, 1954	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$ 37,410.74	$ 20,602.36	$ 16,808.38
RECEIPTS:			
Membership dues	103,340.00	100,883.00	2,457.00
Income from exhibits	13,150.00	20,705.00	(7,555.00)
Interest income	4,718.00	5,104.00	(386.00)
Instructional courses	485.50	513.00	(27.50)
Sale of book "One Hundred Years of Indiana Medicine"	2.50		2.50
Total—exhibit A	121,696.00	127,205.00	(5,509.00)
Redemption of securities	5,000.00	30,000.00	(25,000.00)
Total receipts	126,696.00	157,205.00	(30,509.00)
BEGINNING BALANCE PLUS CASH RECEIPTS	164,106.74	177,807.36	(13,700.62)
DISBURSEMENTS:			
Transfer of applicable portion of dues to The Journal of the Indiana State Medical Association—exhibit D.	11,382.00	11,370.00	12.00
Medical Defense fund—exhibit E	4,552.50	4,450.00	102.50
Premium on purchase of securities	21.52		21.52
Headquarter's office expense	51,785.19	46,165.76	5,619.43
Publicity Committee	590.17	693.58	(103.41)
Public policy	4,780.24	802.97	3,977.27
Council	983.40	1,717.47	(734.07)
Officers	4,191.99	4,196.55	(4.56)
Annual session	11,285.19	16,834.23	(5,549.04)
Standing committees	9,011.25	21,991.85	(12,980.60)
Special committees	1,147.05	909.51	237.54
Federal insurance contributions tax	482.40	380.86	101.54
Indiana unemployment compensation and excise tax	72.01	64.17	7.84
Fifty-year club	321.60	330.07	(8.47)
Women's Auxiliary to I.S.M.A.		10.10	(10.10)
Six-state conference		(22.00)	22.00
General practitioner award	2.70	1.50	1.20
Increase in petty cash fund		500.00	(500.00)
Total—exhibit A	100,609.21	110,396.62	(9,787.41)
Purchase of securities	50,000.00	30,000.00	20,000.00
	150,609.21	140,396.62	10,212.59
CASH BALANCE AT END OF YEAR	$ 13,497.53	$ 37,410.74	$(23,913.21)

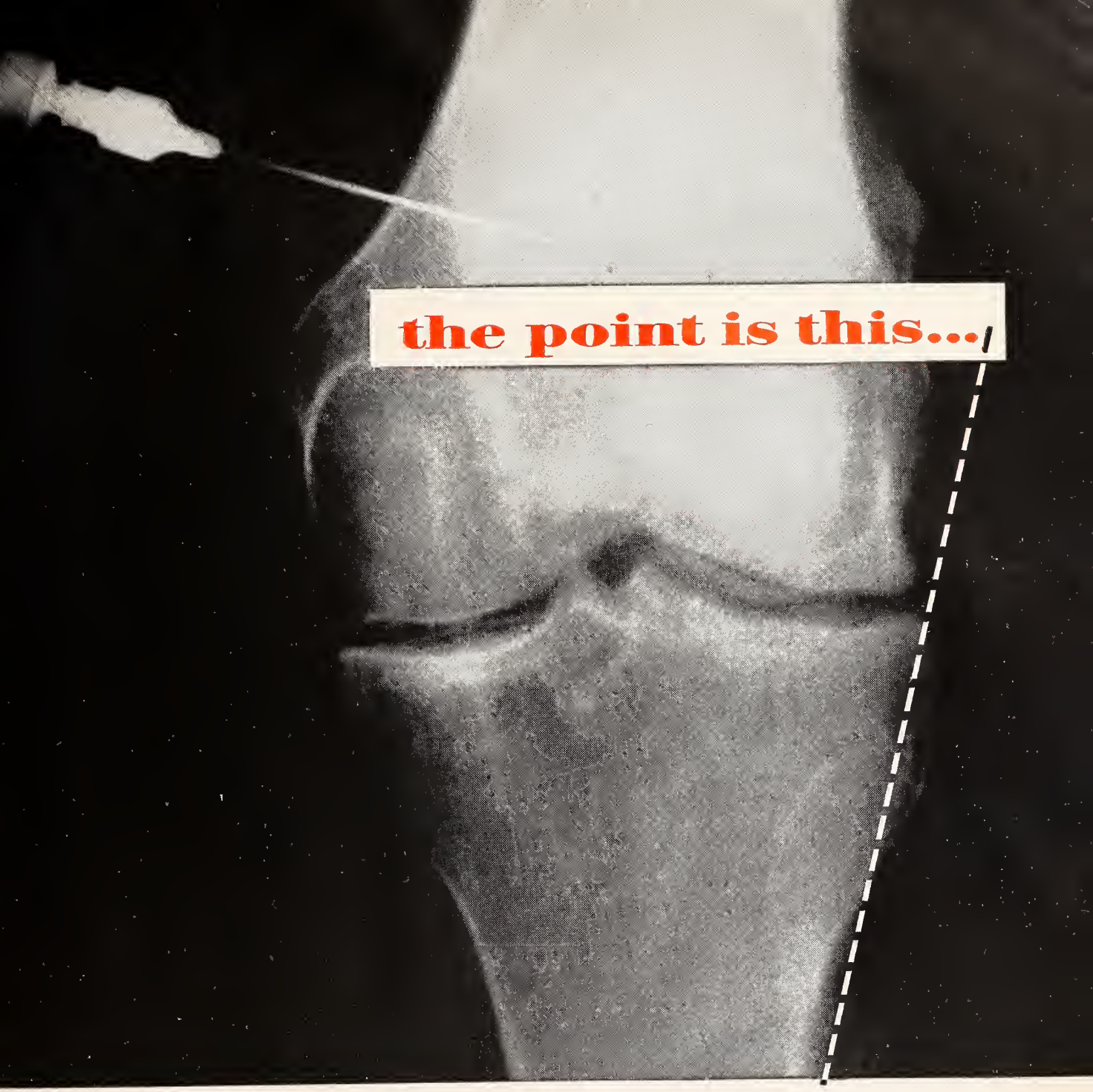
Exhibit D

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1955

THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

BALANCE, JANUARY 1, 1955		$6,078.97
RECEIPTS:		
Subscriptions—members—Exhibit C	$11,382.00	
Subscriptions—non-members	571.00	
Advertising	37,413.63	
Collections on accounts receivable	161.20	
Single copy sales	173.75	
Sale of reprints	2,409.80	
Sale of scrap metal	15.41	
Total receipts—exhibit A		52,126.79
		$58,205.76
DISBURSEMENTS:		
Salaries	10,090.00	
Printing and reprints	35,768.83	
Office expense	736.97	
Electrotypes	2,046.83	
Press clippings	142.70	
Rent and electricity	635.36	
Postage	922.50	
Telephone and telegraph	256.90	
Federal insurance contributions	181.80	
Indiana employment compensation tax and excise tax	31.56	
Blue Cross hospital insurance	82.80	
Copyright fees	48.00	
Miscellaneous supplies	18.30	
Envelopes	132.30	
Photographs	71.05	
Miscellaneous	107.24	
Total disbursements—exhibit A		51,273.14
BALANCE, DECEMBER 31, 1955—exhibit B		$ 6,932.62



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Exhibit E

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1955

MEDICAL DEFENSE FUND

BALANCE, JANUARY 1, 1955		$ 8,059.31
RECEIPTS:		
Transfer of applicable portion of dues from the general fund—exhibit C	$ 4,552.50	
Interest	413.86	
Total—exhibit A	4,966.36	
Redemption of securities	2,000.00	
Total receipts		6,966.36
		15,025.67
DISBURSEMENTS:		
Malpractice fees	3,402.03	
Attorney fees	3,090.00	
Treasurer's bond	37.50	
Total disbursements—exhibit A		6,529.53
BALANCE, DECEMBER 31, 1955—exhibit B		$ 8,496.14

Dr. Frank B. Ramsey, editor of THE JOURNAL: "At the last editor's conference in Chicago, conducted by the A. M. A. State Journal Advertising Bureau, of the thirty-three member journals, the Indiana Journal was rated third highest in the group. I understand there was less than one-half of one per cent difference between the first three journals, as they were rated."

Dr. Cleon A. Nafe, delegate to the A. M. A., discussed actions taken by the A. M. A. House of Delegates at the clinical meeting held in Boston, November 29 through December 2, mentioning especially the acceptance of the resolution which originated in Indianapolis and which was directed to improving the status of the general practitioner, and the adoption of guides for grievance committees. (See January, 1956, JOURNAL for detailed report.)

Dr. Nafe reported that he had asked to be relieved of membership, which he had held for three years, on the so-called Review Committee of the National League for Nursing, created about three years ago as a result of action of the Indiana House of Delegates and Council on the resolution introduced by Tippecanoe County calling for accreditation of nursing schools. . . . "I don't think anything has been accomplished with this group, to do what the doctors want done. A feeling exists among the medical profession that there should be a lesser standard for the smaller nurses' training schools than those set up by the National league. The nurses do not think that, any more than there should be lesser degrees of education for men in medical school. At the present time there are 1,006 diploma or hospital schools throughout the United States. Of those, only 221 are fully accredited and 550 of them partially accredited, and it is the feeling of the nurses' group that in 1958, when this program is supposed to be completed, those nurses' training schools that are not accredited will not continue."

The chairman announced that Dr. Bibler had been appointed a member of the Study Committee on Medical Practice of the A. M. A.

UNFINISHED BUSINESS

1. *Medical Education Foundation Fund. Dr. Glock*, chairman of the Committee on Medical Education and Licensure, reported that Indiana physicians had contributed $24,963.91 in 1955—just about half of what was contributed in 1954. "Part of this, I think, is due to the fact that originally many men signed three-year commitments and felt that that was the conclusion of the effort. I think we must realize that if this Foundation is going to succeed we are going to have to support it year after year. . . . The National Medical Education Foundation had set out to obtain ten million dollars a year, of which two million is supposed to be obtained from the physicians. . . . We have three or four films which the committee purchased, trying to show the need for these funds. Our committee feels that the biggest factor in not obtaining the contributions that we need is the lack of understanding of the problem of the individual physicians in the state. We hope to show these films throughout the state, as well as our other projects, to try to get the message to the individual doctors. . . . From a public relations standpoint, as well as obtaining money for the fund, we would like to be able to say that our doctors are giving 100%. I think that is particularly important inasmuch as we have a campaign coming up in the spring on a nationwide basis, the so-called Eighty Dimes Compaign, when the general public is going to be approached to give eighty dimes, a dime to each medical school.

The question of raising A. M. A. dues as a means of obtaining funds for A. M. E. F. was discussed by Drs. Bibler, Glock, Nafe, Ross, Denny and Dudding.

Dr. Glock: "Our resolution calling for a nationwide assessment or a raise in dues, and asking that this be carried to the A. M. A., was defeated at the state meeting, but I believe that our delegates at least reported that this had been discussed at our convention, and it is my understanding that the A. M. A appointed a committee to study this at the next meeting."

Dr. Nafe: "It was recommended that the Board of Trustees give consideration to a dues increase for all Association members, with the increase designated for contributions to the American Medical Education Foundation. Now, the Board of Trustees is to report back to the House of Delegates, and I think your delegates should be instructed as to how they should vote on this if they come back

for that. That probably will be considered in June."

Dr. Denny explained that the trust fund was established for use when funds might be needed and would not be available.

"*Danger at the Source,*" a film produced by the Fox Film Company at a cost of $100,000 and donated to the National Medical Education Foundation, was shown. Dr. Glock said the State Association had bought four copies.

"We are giving one to the State Auxiliary with the idea that we think this is a wonderful film and gets the message across in a dramatic fashion. We hope the Auxiliary will show it throughout the state. The field secretaries also have copies to take out to their areas. We hope that you will go back to your districts and encourage the component societies to show this film to the membership. A fourth copy is available on a loan basis to any one of the societies through the state office. This film was prepared not for the medical profession but for the lay public, to assist in obtaining funds from the public for our Foundation, and I think if this drive goes ahead next spring possibly many of the societies would like to borrow these films to show to various of the lay groups, and we will appreciate your publicizing the fact that these films are available and we will appreciate it if you will get these films used."

2. *Retirement plan for State Association employees.* Dr. Dodds, chairman of the Committee on Retirement Plan, distributed copies of the proposed retirement plan for state association employees which his committee had worked out with the assistance of the Howard E. Nyhart Company of Indianapolis. He explained that it was the committee's idea that this plan could be financed by interest income from the association's investments and from income other than membership dues. On motion of Drs. Dodds and Dudding, the Council adopted the plan of the Howard E. Nyhart Company and directed the Executive Committee to designate the insurance company which is to underwrite the plan and authorized the Executive Committee to put the plan into effect.

1956 ANNUAL CONVENTION AT INDIANAPOLIS

1. *Dates.* Tuesday, Wednesday and Thursday, October 16, 17 and 18, 1956.

2. *Budget.* At the request of Dr. James M. Leffel, chairman of the local Committee on Convention Arrangements, a budget of $8,000.00 was allotted the local entertainment committee on motion of Drs. Bibler and Dudding.

3. *Scientific program. Dr. Jack E. Pilcher,* chairman of the Committee on Scientific Work, announced that his committee had held one meeting and the program was outlined generally, but the



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detailed program would not be available until the next Council meeting.

Dr. Pilcher reported that the question of holding instructional courses was discussed, the general opinion of his committee being that these courses are not well attended; hence it was decided tentatively not to have these courses.

Following discussion by the Council, on motion of Drs. Ross and Hammond, an analysis of the registration at the instructional courses in past years was to be mimeographed and sent to each councilor and a post card vote taken regarding the sentiment for continuance or discontinuance of the instructional courses during the 1956 convention.

4. *Scientific exhibit.* The request of Dr. J. L. Arbogast, chairman of the Committee on Scientific Exhibits, for a budget of $1,295.00 was approved on motion of Drs. Bibler and Ross.

MEMBERSHIP PROBLEMS

1. 1955 Membership Report by Districts:

MEMBERSHIP REPORT

Indiana State Medical Association
December 31, 1955

County Society	No. M.D.'s in County	Members Dec. 31, 1955	Members Dec. 31, 1954	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District									
*Posey	15	12	11	1	2	1	1	--	--
*Vanderburgh	214	196	191	5	7	13	17	6	2
*Warrick	18	12	11	1	2	--	5	--	--
Spencer	11	9	7	2	--	1	2	--	--
Perry	10	10	11	−1	--	--	--	--	--
Gibson	21	19	22	−3	1	--	1	3	--
Pike	7	6	7	−1	1	--	1	1	--
Total	296	264	260	4	13	15	27	10	2
2nd District									
*Knox	43	39	43	−4	3	1	3	1	--
Daviess-Martin	31	26	27	−1	4	--	3	1	--
Sullivan	14	14	15	−1	--	--	--	--	--
Greene	19	19	21	−2	--	--	--	1	--
*Owen-Monroe	57	52	52	--	4	2	2	1	--
Total	164	150	158	−8	11	3	8	4	--
3rd District									
Lawrence	30	25	22	3	1	2	4	--	--
Orange	12	9	8	1	3	--	--	--	--
*Harrison-Crawford	14	13	12	1	1	--	--	--	--
Washington	8	8	8	--	--	--	--	1	--
Scott	6	3	4	−1	1	--	2	--	--
Clark	35	30	32	−2	4	3	3	--	--
*Floyd	39	36	34	2	2	1	1	--	--
*Dubois	22	20	20	--	2	--	2	--	--
Total	166	144	140	4	14	6	12	1	--
4th District									
*Bartholomew-Brown	37	35	34	1	--	1	2	--	1
Jackson	21	20	20	--	--	--	1	--	--
Decatur	16	12	13	−1	2	--	2	--	--
*Jennings	9	9	10	−1	--	--	2	--	--
Ripley	16	14	13	1	2	1	--	--	--
Jefferson-Switzerland	31	24	24	--	6	1	4	--	--
*Dearborn-Ohio	15	14	15	−1	1	--	--	--	1
Total	145	128	129	−1	11	3	11	--	2
5th District									
Parke-Vermillion	27	18	23	−5	5	1	4	1	--
*Putnam	16	16	17	−1	--	--	1	--	--
Vigo	128	123	119	4	3	5	9	1	1
Clay	14	12	13	−1	--	--	3	--	--
Total	185	169	172	−3	8	6	17	2	1
6th District									
Hancock	17	17	18	−1	--	--	1	1	--
*Henry	42	39	37	2	3	3	2	1	--
*Wayne-Union	89	78	74	4	4	4	7	2	3
Rush	17	16	18	−2	..	..	2	..	..
Fayette-Franklin	25	24	21	3	--	--	2	--	--
Shelby	22	18	21	−3	1	--	2	1	--
Total	212	192	189	3	8	7	16	5	3
7th District									
Hendricks	20	17	17	--	1	--	--	1	1
Marion	1040	952	936	16	57	69	83	17	11
Morgan	19	17	18	−1	1	1	2	..	..
Johnson	25	22	22	--	2	1	1	--	1
Total	1104	1008	993	15	61	71	86	18	13
8th District									
*Madison	110	102	98	4	4	1	3	1	2
*Delaware-Blackford	116	100	101	−1	10	2	5	2	3
*Jay	21	18	16	2	2	1	1	1	--
Randolph	27	23	23	1	2	2	2	--	1
Total	274	243	237	6	18	6	11	4	6
9th District									
Benton	11	8	11	−3	3	--	--	1	--
*Fountain-Warren	18	16	16	--	1	3	2	--	--
*Tippecanoe	107	92	92	--	9	2	10	4	--
*Montgomery	32	30	29	1	--	1	3	--	--
Clinton	25	23	22	1	2	2	1	1	--
Tipton	15	12	11	1	--	--	3	--	--
*Boone	25	21	20	1	3	--	1	1	--
Hamilton	24	18	20	−2	4	1	2	1	1
White	11	10	10	--	--	--	--	1	1
Total	268	230	231	−1	22	9	22	9	2
10th District									
Lake	373	357	343	14	9	24	25	6	1
*Porter	34	32	29	3	2	3	1	2	--
*Jasper-Newton	21	19	19	--	2	--	4	--	--
Total	428	408	391	17	13	27	30	8	1

County Society	No. M.D.'s in County	Members Dec. 31, 1955	Members Dec. 31, 1954	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
11th District									
Carroll	10	9	9	--	1	--	--	--	--
*Cass	47	36	36	--	5	--	5	1	3
*Miami	26	22	21	1	2	--	1	1	1
Wabash	27	23	23	..	2	1	3	..	..
Huntington	24	20	21	1	3	--	--	--	1
Howard	50	45	42	3	1	3	5	1	2
*Grant	66	55	51	4	9	6	2	--	--
Total	250	210	203	7	23	10	16	3	7
12th District									
LaGrange	9	9	9	--	--	--	--	--	--
Steuben	18	13	14	-1	1	1	2	3	--
*Noble	25	24	26	-2	1	--	4	--	--
DeKalb	21	20	20	--	1	--	2	--	--
*Whitley	13	11	11	--	2	1	--	--	--
Allen	248	236	227	9	3	13	15	2	4
Wells	35	29	28	1	4	4	4	--	--
Adams	16	15	13	2	1	1	--	--	--
Total	385	357	348	9	13	20	27	5	4
13th District									
LaPorte	101	92	89	3	8	3	8	2	--
*Elkhart	101	93	94	-1	4	2	8	--	--
St. Joseph	242	219	214	5	16	6	12	--	3
*Starke	8	8	7	1	--	1	--	--	--
Pulaski	6	5	6	-1	1	--	--	--	--
Fulton	13	13	12	1	--	1	1	--	--
Marshall	25	20	22	-2	4	--	--	--	1
Kosciusko	16	14	12	2	1	1	2	--	--
Total	512	464	456	8	34	14	31	2	4

SUMMARY BY DISTRICTS

County Society	No. M.D.'s in County	Members Dec. 31, 1955	Members Dec. 31, 1954	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District	296	264	260	4	13	15	27	10	2
2nd District	164	150	158	-8	11	3	8	4	--
3rd District	166	144	140	4	14	6	12	1	--
4th District	145	128	129	-1	11	3	11	--	2
5th District	185	169	172	-3	8	6	17	2	1
6th District	212	192	189	3	8	7	16	5	3
7th District	1104	1008	993	15	61	71	86	18	13
8th District	274	243	237	6	18	6	11	4	6
9th District	268	230	231	-1	22	9	22	9	2
10th District	428	408	391	17	13	27	30	8	1
11th District	250	210	203	7	23	10	16	3	7
12th District	385	357	348	9	13	20	27	5	4
13th District	512	464	456	8	34	14	31	2	4
Total	4389	3967	3907	60	249	197	314	71	45

*Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

120 physicians received membership gratis in 1955 because of military service

268 physicians were senior members in 1955.

2 physicians were honorary members in 1955.

129 physicians paid dues of $10.00 in 1955 as residents and interns.

67 physicians had their dues remitted by the Council in 1955.

2. *Remission of state dues.* On motion of Drs. Dodds and Ross, requests from Gibson, Marion, St. Joseph and Vanderburgh counties for remission of dues of seven members, due to retirement, hardship, or illness, were approved.

New Business

1. *Matters referred to Council by Executive Committee:*

a. *Rotating loan fund for medical students. Mr. Stump*, attorney, read the Trust Fund Agreement which had been drawn up, and which was approved by the Council on motion of Drs. Dodds and Glock, with the following two amendments, proposed and approved by the Council:

(1) One member of the Loan Committee, which is to be named by the president of the State Association, shall be a member of the state Committee on Medical Education and Licensure.

(2) Insurance on the person granted a loan shall be carried either by the Indiana State Medical Association or by the individual, this to be at the discretion of the Loan Committee.

The agreement, embodying the above amendments, was approved as a whole on motion of Drs. Ross and Glock, and is as follows:

DECLARATION OF TRUST

Indiana State Medical Association, pursuant to a resolution adopted by the House of Delegates on October 19, 1955, hereby constitutes and declares itself to be the trustee of a charitable trust established by the appropriation for that purpose by the said Association of $10,000.00 for a Medical Student Loan Fund to be handled, managed and operated in the following manner, and upon the following terms and conditions:

1. CREATION OF A COMMITTEE.

A Committee to make loans from the said fund to medical students needing financial aid to further their medical education, shall be constituted as follows:

(a) The total number on the Committee shall be seven, four of whom shall be appointed by the President of the Association and shall have the following qualifications: One shall be from the membership at large, without regard to whether he is a general practitioner or a specialist, and, if so, of what specialty; one shall be a District Councilor; one shall be a general practitioner; and one shall be a recognized specialist, of a specialty not otherwise represented on the Committee. One of the appointive members shall be from the membership of the Committee on Medical Education and Licensure. The appointments of two of these four members shall be for one year, and of two, for two years; and all appointments thereafter to fill vacancies resulting from expiration of terms shall be for two years. The remaining three members of the Committee shall be: The Treasurer of the Association, the Dean of Indiana University School of Medicine, and one of the Legal Counsellors of the Medical Association, to be assigned to that work by the President.

(b) The appointments shall be made on or before ———— of each year, beginning with the year 1956.

2. ORGANIZATION OF COMMITTEE.

After the appointment of the appointive members of the Committee, the Committee shall assemble within ———— days upon the call of the Treasurer of the Association at a time and place to be stated in the

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notice of the call, which shall be sent to all members. In this first meeting the Committee will organize itself by the election of a Chairman and a Secretary. Officers shall hold office for one year and until their successors are elected. They may succeed themselves in office.

3. ADOPTION OF RULES OF OPERATION.

The Committee shall, with the approval of the Executive Committee or the Council, make rules appropriate to the operation of the Committee in such form as they may determine, to carry out the purposes of this trust which are more fully stated in the resolution establishing the student loan fund.

4. GENERAL REGULATIONS

(a) Applications for loans shall be made by students desiring loans, in the form prescribed by the Committee. All applications for loans shall be delivered to the Chairman, and he shall investigate each applicant in a thorough manner, and shall, if possible, within ten days after receiving the application inform each member of the Committee of whatever he finds regarding the advisability of making the loan.

(b) No loan to any one student shall be for more than $500.00 during any one school year, and the total of all loans to any one student shall not be more than $1,500.00. The Committee may, within its discretion, require security in the form of life insurance.

(c) The borrower shall execute a negotiable promissory note, which in case of a married student shall also be signed by the spouse, which note shall be payable to the Medical Student Loan Fund, and shall bear interest from the date of completion of interneship or withdrawal from medical school or hospital, at the rate of 3½ per cent per annum. There shall be no interest charge before the student borrower completes his interneship or withdraws from the medical school or hospital.

(d) The date of maturity of any note shall be fixed by the Committee in accordance with its discretion exercised in regard to the facts in each case, but with the understanding that the note is to be paid when due.

(e) The Committee shall exercise its own discretion as to the method of collection, but with the understanding that diligent effort shall be made to collect when and after the note becomes due; and in that connection the Committee may exercise its discretion as to extension of time for payment or renewal of a note, and as to any action, by suit or otherwise, to be taken to collect after due.

(f) The student borrower shall agree in making his application for a loan that he will repay the loan as early as he has either funds or credit available through which he can make payment, whether it is due or not, so that the fund may be replenished for further loans and as many students as possible may be accommodated.

(g) The Committee need not meet as a body to pass on loans, but loans may be made at any time in the following manner:

(1) When an application for a loan is in proper form the Secretary of the Committee shall send a copy of the application with the report of the Chairman thereon, to each of the members of the Committee, on which each member shall write and sign his disapproval or his approval, indicating the amount for which he approves.

(2) If four or more members of the Committee approve a loan for a certain amount, the Treasurer of the Society shall issue a check to the borrower on the said fund for that amount, which check shall be countersigned by the Chairman of the Council or other officer or employee of the Association duly authorized to counter-sign checks.

5. ADDITIONS TO, AND AUDITS OF THE FUND.

The Committee shall have the right to accept contributions to the fund from any source. An accurate account of the operation of the fund shall be kept and shall be audited annually in connection with the audit

of the Association as one item which shall be covered in the annual audit.

IN WITNESS WHEREOF, this Declaration of Trust is executed by the Indiana State Medical Association, this ———— day of ————, 19—.

President

Secretary

b. *Attorney-general's ruling on legality of nurses doing venipunctures.*

Mr. Stump: "At the time the state convention met a reference was made to one of the committees concerning nurses doing venipunctures and the committee was informed by one of the physicians on the State Board of Medical Registration and Examinaton that the attorney-general had declared that that kind of service constituted the practice of medicine and was illegal. The attorney for the State Nurses' Association made some investigation regarding the statement of the attorney-general and the attorney-general said that his opinion in that regard had been misunderstood."

On motion of Drs. Ross and Glock, this matter was referred to the next meeting of the House of Delegates.

2. *Preceptorship program. Dr. Bibler,* chairman of the Subcommittee on Preceptorships, reported that it had been suggested to his committee that a member of the Subcommittee on Preceptorships of the state association, with a member of the Council of the Medical School, visit one of the medical schools which already has a preceptorship program in operation. On motion of Drs. Bibler and Ross, the Council authorized this investigation, the Subcommittee member's expenses to be paid by the Indiana State Medical Association.

3. *HR 7225. Dr. Kennedy* called attention to the resolution introduced in the A.M.A. House of Delegates at the Boston meeting which states the American Medical Association's objection to the adoption of HR 7225, the Social Security bill. On motion of Drs. Kennedy and Dudding the Council approved the attitude and the resolution of the A.M.A. and the Indiana congressmen are to be so informed.

4. *Public Relations program. Dr. Earl W. Mericle,* chairman of the Committee on Public Relations, presented three recommendations of his committee for consideration of the Council.

a. *Science fairs.*

"Your Committee on Public Relations at its meeting on January 8, discussed the matter referred to the various states by the American Medical Association, in which the states were requested to participate actively in the conduct of Health Science Fairs.

"The Board of Trustees of the A.M.A. has approved participation at the National level, and among other means of participation, the winners at

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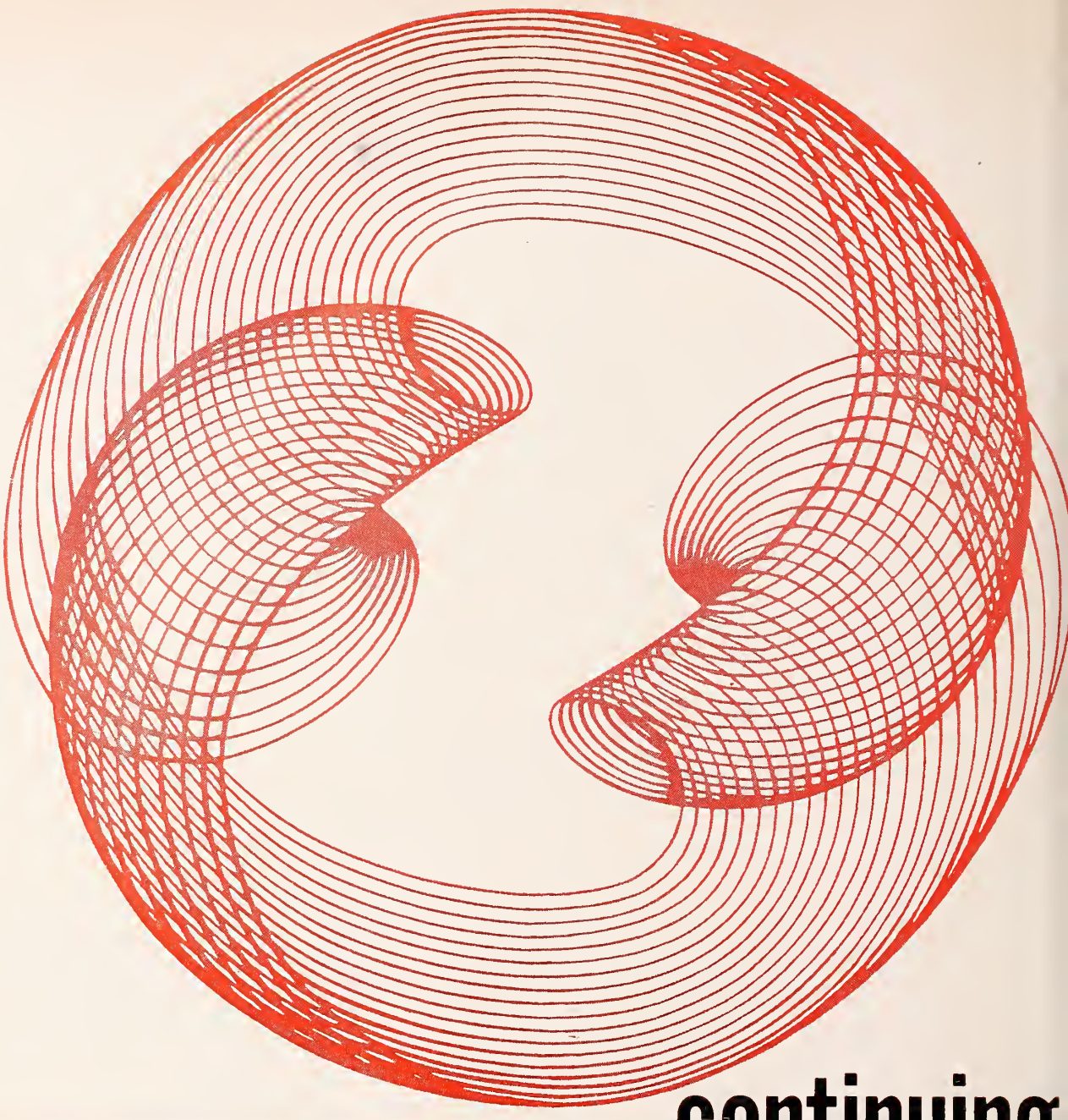
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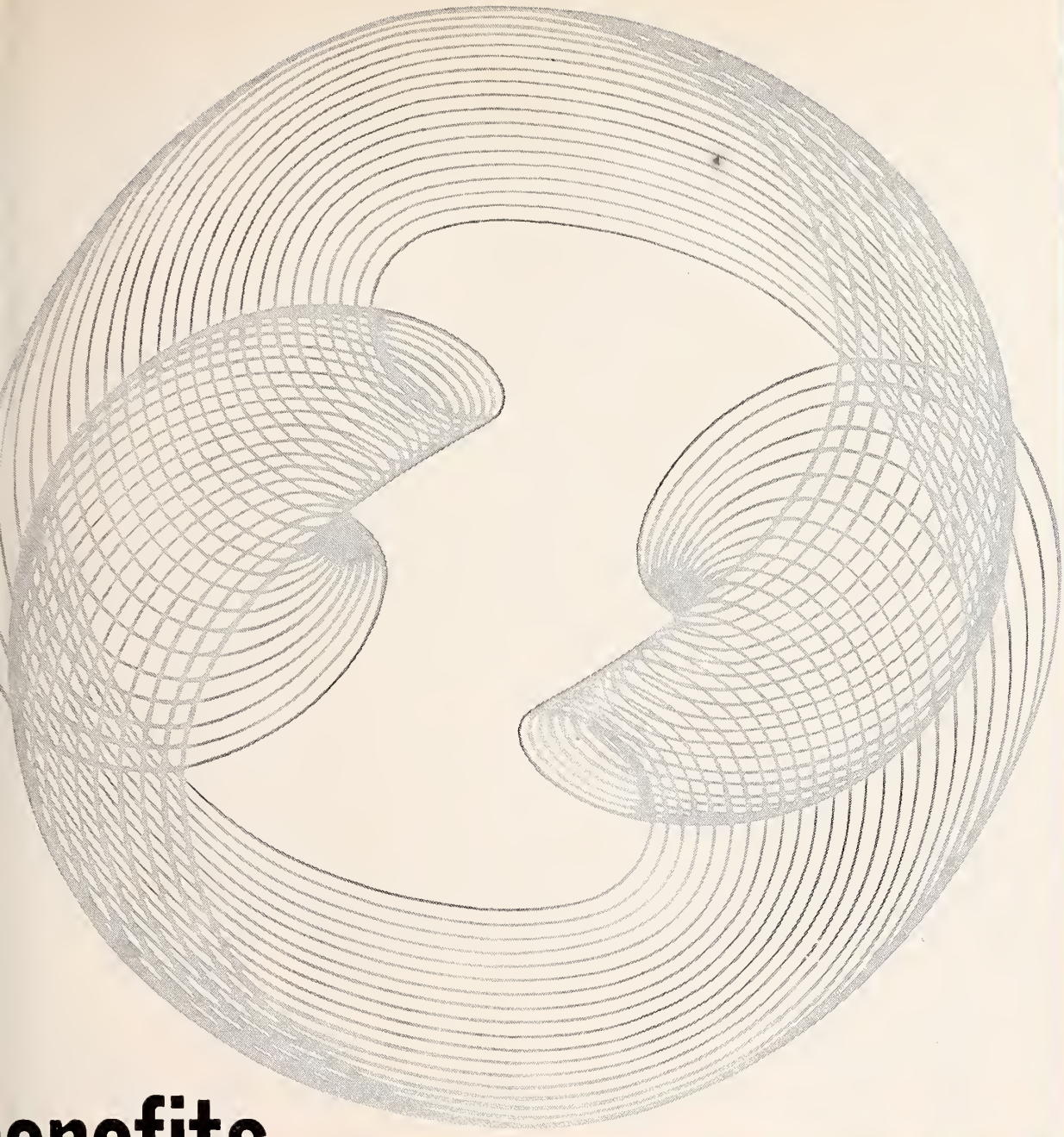
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the National Science Fair will exhibit their winning entries as a part of the scientific exhibit at the annual meeting of the A.M.A. at A.M.A. expense.

"It was pointed out medical participation in this program offered not only a constructive activity by organized medicine but also a positive public relations program.

"Science Fairs have been sponsored by the Porter County Medical Society for three years. This society has the reputation of being among if not the first county medical society to undertake this as a project. The Indianapolis Medical Society has cooperated with Indianapolis newspapers in conducting a regional science fair in Indianapolis.

"Your Public Relations Committee would recommend that the Council approve the plan of the Committee to urge component county societies to participate actively in these health science fairs, that they contact the science teachers of their high schools informing them of their interest, and attempt to encourage participation by the students of their high school in this program; and further that the members of the county society offer themselves as consultants to students who will need technical advice and assistance in developing their projects.

"We further recommend that the Indiana State Medical Association take an active part (1) By appropriating $3,500 to defray the expenses of sending the winners from the regional districts, and their teachers to the National Fair at Oklahoma City. Purdue University Flying Service has submitted the cost of flying all these to Oklahoma City and return, including insurance on each passenger. $3,500 is deemed necessary to defray these expenses. Other organizations are cooperating in defraying other expenses of the regional fairs and the national registration fee, and we feel the $3,500 is a proportionate share of the expense of this program in Indiana.

"We would further recommend that the Council recommend to the Committee on Scientific Exhibit, that winning exhibits in the health sciences be screened for use in the scientific exhibit of our annual convention."

On motion of Drs. Bibler and Dudding the Council accepted Dr. Mericle's recommendation that the Association participate in science fairs and that $3,500.00 be appropriated to pay the traveling expenses of the winners to the National Fair at Oklahoma City. On motion of Drs. Topping and Bibler the appropriation for this expense is to come from the budget allotted the Public Relations Committee.

On motion of Drs. Bibler and Dudding the Council accepted the recommendation relative to encouraging county medical societies to assist in science fairs and that students with winning exhibits in the health sciences be permitted to exhibit at the state medical association meeting.

b. *Polio vaccine. Dr. Mericle:* "In another matter considered by your standing Committee on Public Relations at its meeting January 8 was the following: 'Polio Vaccine Program as It Affects Professional Public Relations.' We believe the polio program has a definite bearing on the total public relations of our organization. We would therefore like your approval of two actions taken by our committee.

"(1) That we undertake a program of information to our membership designed to inform the individual physician that he may write direct to the Indiana State Board of Health or to his local Health Officer and request whatever free vaccine (supplied through Federal funds) he needs for administration to his patients."

On motion of Drs. Ross and Glock the Council approved sending out a letter from the headquarters office to each member of the Indiana State Medical Association containing the above information. This applies only to the present allocation of polio vaccine.

"(2) That we urge Admiral Groesbeck, director of the Department of Health of Indiana, that he consider stockpiling syringes, needles and other necessary supplies for loan to and use by county medical societies conducting mass immunization programs."

On motion of Drs. Dudding and Challman, the Council rejected this proposal of the Public Relations Committee.

Dr. A. C. Offutt, State Health Commissioner, appeared before the Council and discussed the polio vaccine situation.

c. *Amended welfare regulation. Dr. Norman R. Booher,* president of the State Welfare Board, spoke of the public welfare program, public-relationswise, saying, "There is no part of the public welfare program across which medical problems do not cut." He summarized costs, telling of the changes in reporting procedures which were made two years ago whereby the cost of medical care supplied recipients is broken down into the services of physicians, hospitals, dentists, pharmacists, nursing homes, etc., which has taken some of the mounting medical costs in welfare programs off the backs of the medical profession. During the past two years the welfare dollar was received as follows by the different medical groups:

	1953-54	1954-55
Hospitals	26.9%	25 %
Nursing homes	33.8%	37.2%
Pharmacists	9.1%	9.8%
Dentists	1 %	8 %
Physicians	26.7%	24.6%
All others	2.5%	2.6%

Dr. Booher stated that a State Advisory Committee on Welfare Medical Program had been formed with at least one member on the committee from



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References: 1. Bunim, J. J., et al.: J.A.M.A. 157:311, 1955. 2. Forsham, P. H., et al.: Paper presented at First Internat. Conf. on Prednisone and Prednisolone, New York, May 31-June 1, 1955. 3. Perlman, P. L., and Tolksdorf, S.: Scientific Exhibit presented at A.M.A. Annual Meet., Atlantic City, June 6-11, 1955.

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

*brand of prednisolone

each organization which received money from the medical program of the Welfare Department last year. These organizations are:

Indiana State Medical Association
Indiana State Association of County Welfare Directors
Indiana State Nurses Association
State Association of County Welfare Board Members
Indiana Pharmaceutical Association
Indiana Association of Licensed Nursing Homes
Indiana Hospital Association
Indiana State Dental Association
Optometry Association
Funeral Directors Association
Two members of the Legislature
A representative of the Indiana University Medical Center

This group is to serve in an advisory capacity to the State Welfare Board "to tell the Board that we are either doing the job wrong and wherein we are doing it wrong, or to help us justify what we are doing, how we are doing, and how much money we are spending."

Dr. Booher also spoke of the new regulation established by the Welfare Board which makes advisory committees at the county level a mandatory part of each county program, and which is as follows:

"The health services plan of a county Department of Public Welfare shall provide for an appointment and use of a health advisory committee. The committee shall be appointed by the county board and shall consist of representatives from the professional groups who participate in the health service program of the county, and other persons who represent the community and civic interests. The Health Advisory Committee shall elect its own chairman and the director of the county Department of Public Welfare shall elect the secretary. Two or more counties may join together in the appointment and use of the same health advisory committee and the joint health advisory committee shall designate one of the directors of such counties to act as secretary. The health advisory committee shall have at least one meeting every three months."

"In the MANUAL OF PUBLIC ASSISTANCE the words, 'Medical Assistance Plans' and 'medical assistance' have been changed to read 'Health Services Plans' and 'health services' in an attempt to change the welfare program, in the minds of the public, from a medical program to a health service program, which will be more representative of what the Welfare Board is doing," Dr. Booher said.

Dr. Mericle announced that a public relations meeting would be held in Indianapolis on February 19 for the purpose of implementing the public relations organization as approved by the House of Delegates at the 1955 annual convention. All councilors have had notification that they will either attend or send someone who will represent their respective districts.

5. *Medical education. Dr. Bibler* spoke of the medical practice resolution which was passed by the American Medical Association at Boston, which contained two pertinent resolves:

(1) That the formation of a Department of General Practice in each of the medical schools be encouraged; and

(2) That training in general practice in all medical schools be stimulated.

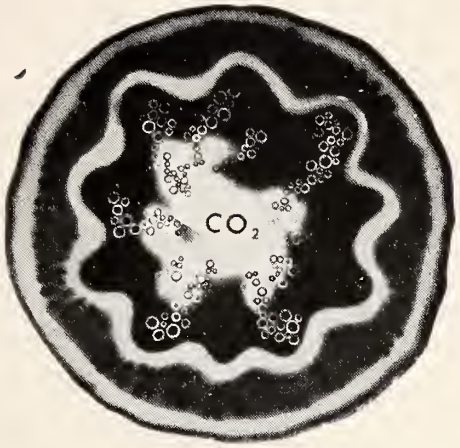
"There has been considerable discussion by doctors throughout the state, particularly those in general practice, relative to some suggestions of altering our type of medical education, particularly in reference not only to general practice but to medical economics and other phases. . . . At this time I wish to bring this subject to you for discussion. I would like to have the privilege of having Dr. Booher, Dr. Green and Mr. Palmer talk on this subject." (Taken by consent.)

DR. BOOHER: "First, I would like to say that in the remarks that we make today we have no reflections whatsoever on the present teaching of medical economics or kindred subjects in the medical school. . . . For a long time we have been thinking that there should be some place in the faculty of Indiana University School of Medicine for men doing general practice, to have some place on the faculty to come in contact with the students, both for the student's good and for the good of the general practitioner. As Dr. Bibler has said, the AMA very forcibly brought that to national attention at the Boston meeting in the resolution passed there, asking that each medical school establish a Department of General Practice, if possible."

THE CHAIRMAN: "Certainly this is an important subject. Do you want to discuss it further, or would you like to refer it to our Committee on Education for further study?"

DR. BOOHER: "We are perfectly content to present this matter to the Council for whatever action it sees fit. We certainly would like to have the constructive thinking and help of Dr. Glock's committee. We are not in any hurry; we know we cannot do this in a day. We want to get started, and we hope it will run into a snowball."

DR. GLOCK: "I greatly appreciate your opinions and these matters that are brought up — these things recur from year to year and I am sure that again this year we will go to Dr. VanNuys as we have done in the past, partially due to this discussion and partially due to the action taken at the AMA level asking for a Department of General Practice. However, I will point out . . . Dr. VanNuys has the problem with his curriculum of trying to fit in what everybody wants, and it is a very difficult thing because it is loaded. . . . As far as the General Practice Department is concerned, the attitude that John has taken in the past is that



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he wants to present every subject in the best way that can be done by the most able men. Now, if there is a general practitioner who is the most able in a certain field, that is the man who should be used. I talked this over with one of our young general practitioners at home and he felt possibly if they could utilize within the existing departments some of the general practitioners, say men who are particularly interested in obstetrics, or medicine, or surgery, use them as instructors, or use them as assistants in clinics and things like that.

"Now on this economic thing and the things that Joe Palmer brought up, those problems are not peculiar to the general practitioner; they are peculiar to all of us, and just because a man has had a residency in medicine or surgery or ophthalmology, doesn't say that he knows more about economics or about getting a state license or becoming a member of the society. We are all in the same boat. And I think if the idea is to set up a department designed just to take care of the needs of the men who are going into general practice, I think all of them need that, and I quite agree with you that probably there should be more of this information brought out in the medical school, and there again your committee will be glad to work with the University and see what can be done along those lines. Much of this in Twyman's letter and what Mr. Palmer talked about, properly should be a matter of importance to the local society. Now, it is my understanding that Indianapolis has a very fine system; when a young man comes in and applies for membership he is assigned a sponsor and he is to attend classes or meetings for a year or two, or three-year period, to teach him about the public relations angle and what does the AMA mean and what facilities does your society furnish you, what service? And I think that many of these things that have been suggested be presented in the medical school are more properly a function of the medical society, and recently in my own medical society we have adopted at least a portion of the so-called Indianapolis plan where we are going to require that our applicants for membership, even after they become members of the society, must attend a certain number of meetings; and, for instance, the chairman of our Public Relations Committee will have a session with them and explain to them what we are trying to accomplish. We hope to have a series of those meetings in order that those men may become familiar with what the medical society is and what it does. Now, I'll grant that you have to teach them in school, or you should, that it is desirable that they become a member of their medical society, but I think the proper place for many of these things that Twyman and Palmer are talking about is within the medical society itself. I mean these new members have an obligation to the society which they join just as we have an obligation to them. And I feel that if your Indianapolis plan works it should take care of a good deal of comments that have been made relative to some of these things regarding the ignorance on the part of these individuals. I think a lot of that could be taken care of at a local level."

Dr. Dudding said that he had talked with Mr. Mahoney on this matter from the rural health standpoint and the man going into rural practice, and he had suggested that possibly such a course could be put in the curriculum on an elective basis.

Dr. Denny submitted the following idea: That the State Association encourage the Medical School to farm senior and junior medical students out for a three months' period to the various small hospitals in the state. "The county society will see to it that they learn how a small town hospital operates and will teach them the ethics of a small town practice. . . . You will do two things, you will educate your medical student; he will see what general practice is out in the country."

"The State Association should propose to the Medical School to send the Senior and Junior Medical students out to the various small hospitals of the state for a three month period. This would work much better than the Preceptorship program as it has been so far proposed. The County society members should see to it that these students are properly housed either in the hospital if they be single, or in other quarters if married.

"They should work in the hospital of mornings and nights. Then make office and house calls with the various general practitioners of the county in the afternoon, thus observing first hand the actual work of general practice.

"Such a procedure will accomplish what has been discussed here and in addition teach the medical student the art of general practice in the home, hospital and office. It will also be an elevating experience for the doctors that engage in such a venture. I have reasonable assurance that this program can be carried out by the School and the physicians in our state."

Dr. Bibler said that the reason for bringing this subject up is the fact that this year the first two years of the medical curriculum are being revised. Next year the last two years will be revised. "The purpose of this discussion is to give our educational committee some further assistance so they can go to the Medical School Council and offer these suggestions and if we can get an endorsement of the Council of the State Medical Society in reference to these particular problems, which we feel have not been taken care of, it will afford Dr. Glock and his committee further ammunition, and we hope the committee takes it in the friendly manner in which it is offered."

The motion of Drs. Bibler and Ross "that this matter be referred to the proper committee for disposition and keep us advised as to any future improvement in the situation" was carried, and the chairman announced that this would be referred to the Council Reference Committee on Medical Education, of which Dr. Glock is chairman.

6. *Veterans fee schedule. Dr. James W. Crain,* chairman of the Committee on Veterans Affairs and Rehabilitation, stated that the Indiana State

Medical Association had been under contract with the Veterans Administration to give home service care for service-connected disabled veterans since 1946 or 1947. The contract has been renewed annually since 1947 with no changes.

"There is one clause in this contract that I would like for you gentlemen to give some special consideration to, to determine if there is any way to avoid it. When this state association enters into a contract with the Federal Government we guarantee to do a specific job and it seems to me we should have a specific price level. In this contract under 'FEES' it reads:

> " 'Fees for medical services in authorized cases shall be paid by the Veterans Administration to the physician rendering the service in accordance with the Fee Schedule hereto attached, which is made a part of this agreement. It is mutually understood that the fees stated in the Fee Schedule represent the maximum amount that may be charged, and do not represent the amount to be paid in every case. The Veterans Administration will advise each physician of this provision and will require each physician to certify in submitting his statement of account that the fees charged are not in excess of the fees charged by him for comparable service rendered non-veterans. It is understood that unsually involved cases and services not scheduled will be subject to review and recommendation by the contractor to the Central Office, Veterans Administration, which will determine the appropriate fee.'

"It would be my personal opinion that we should have a flat fee schedule and that if any of you gentlemen guaranteed to do a job for the Federal Government you should have a guaranteed price that is to be paid, and if you decide that Mrs. Jones who lives next door to you is to receive the same services for half the fee, that is your business and not the Federal Government's. If my committee agrees with my thoughts, that will be one of the changes we will recommend, and I think that will be one of the difficulties this society will have in negotiating a new contract.

"At the last meeting of the Liaison Committee, which it was my privilege to attend as a guest, those gentlemen offered to enter into this problem of examining the old contract to determine the need for raising fees if it met with the approval of the Executive Committee.

"Now, our committee has been invited to attend the Liaison Committee meeting on Wednesday afternoon after our meeting. Maybe I am just a little apprehensive, but I can see that we would be open to criticism were we to refuse the invitation. We certainly would be open to criticism for taking a matter such as this to another organization for



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discussion without your consideration. I would like to have the permission of the Council to attend the Liaison Committee meeting and take our fee schedule to them for discussion."

On motion of Drs. Kennedy and Vye the Council approved of the study of the fee schedule with the possibility of changing it, and authorized Dr. Crain to meet with the Liaison Committee of the Legion for the purpose of discussing this schedule.

In regard to "general physical examination," on motion of Drs. Ross and Bibler, the Council empowered Dr. Crain to negotiate the best possible arrangement and use his discretion in the matter of fee in this particular instance and also what should constitute a complete physical examination.

7. *Care of dependents of military personnel.* The chairman stated that each county medical society had received a questionnaire on the care of dependents of military personnel.

The executive secretary explained that this matter had come to the attention of the Association by referral from the Board of Directors of the Blue Shield Plan in the state, asking that a questionnaire sent to them by the Commission of Blue Shield be discussed to ascertain whether or not certain things might be possible in the State of Indiana. The Blue Shield Commission suggested inclusion in the bill proposed by the Defense Department that a program of care for dependents of military personnel be established similar to or the same as the home town care program for veterans, with one exception, that being that the physician would bill the Blue Shield Plan for payment rather than the Veterans Administration. In other words, Blue Shield would act as administrative agent for the Defense Department in this state. "Since the directive went out the bill has been introduced and the home town care provision has been deleted from the bill as it is now before Congress. The plan calls for use of military facilities or for an insurance program which would be contributory upon the part of the military personnel. The AMA a week ago Friday had a conference with the Defense Department and asked why this has been deleted and they had no reply as to why it had been dropped from the bill. I have talked to Washington twice this week, and as of last Friday the Defense Department is now working with the Veterans Administration on seeing how and if it is going to be possible to integrate such a program with the present VA home town care program. The commercial insurance companies have a proposal ready for submission to the Department of Defense for handling this on an insurance basis. I am informed that the provision of Blue Shield acting in any capacity in this matter has been more or less dropped by the Defense Department.

"In the survey of county societies as to whether or not they would go along with a home town care program and whether or not they would cooperate in attempting to establish a fee schedule, out of 82 societies, 27 replied as follows: 14 affirmative; 12 no, and 1 approved tentatively."

THE CHAIRMAN: "It seems to me that the law has changed and so it is a question whether this is even necessary."

8. *Code for autopsy procedures. Mr. Hollowell,* attorney: "Briefly, this is a proposed code but not in a legislative sense, that is, it is not a proposed bill to be presented to the legislature; it is more in the nature of a working arrangement to be agreed upon primarily between the State Hospital Association, Indiana Association of Clinical Pathologists, the Funeral Directors Association, the Coroners Association, and the Medical Association. To some extent it is in the nature of a code of ethics. It is borrowed from Ohio, and the things that it covers are the outlines of the respective functions of the various people whom I have mentioned in connection with an autopsy, such as the respective functions of the pathologist and the funeral director. It covers such things as the preautopsy preparation and care of the body; it covers the method of getting consent and the types of consent that should be obtained. It covers the conduct and the technique of the autopsy and throughout deals with the different functions of the different people involved in an autopsy, such as things the hospital should do, the arrangements that they are to make, the things that the funeral directors should do, etc. I was advised by Dr. Arbogast, with whom I talked about it on Wednesday night, that the purpose of it was that in the past there has been a conflict between some of these people as to understandings, as to just what their respective functions are in connection with the the performance of an autopsy, and that the purpose of this was to have an arrangement agreed upon by all of them so that they would more clearly understand the situation. It will have no legal effect. It is simply a working arrangement between the various people. It does provide for a Board of Arbitration to work out individual situations where there have been nonconformities. Of course, I could not speak upon the medical aspects of it, and if I might make the suggestion, since it is coming to the Association for approval, perhaps some proper committee should look more into the details of it. It is too long, I think, to read at this meeting and go over item by item."

DR. BIBLER: "Has there been any change relative to consent to an autopsy?"

MR. HOLLOWELL: "No. Now, this is not legal, understand, and has no effect upon the legal requirements for consent and could have no effect upon them. It doesn't go to that so much as to advising and recommending the procedure. It has no effect upon any legal requirements as they relate to an autopsy. I think they do have in mind later trying to work some things out in connection with

that and some matters which they might wish to take to the legislature, but that is not involved in this."

THE CHAIRMAN: "I understand that we have a letter here from Dr. Haymond and the Indiana Association of Pathologists in which he states that this code has been approved by the Indiana Association of Pathologists and the funeral directors."

MR. HOLLOWELL: "That's right, and they are asking approval of this association, the hospital association, and coroners. It is a similar code to the state of Ohio. It is not proposed legislation."

On motion of Drs. Bibler, Dudding and Ross, this matter was referred to the Council Reference Committee on Public Health for its recommendation.

9. *Social Security poll.* The executive secretary reported on the results of the poll taken on whether or not physicians wished to be included in the Social Security program, as follows:

3,613 postal cards sent out; 2,333 returned.

703 would be willing to be placed under Social Security. Of the 703, 579 voted for voluntary basis, 91 for compulsory basis.

1,329 do not want Social Security.

1,617 want Reed-Keogh or similar legislation.

256 against Reed-Keogh legislation.

This information is to be forwarded to the American Medical Association.

10. *Nominations for membership on Board of Directors of Mutual Medical Insurance, Inc.* On motion of Drs. Glock and Kennedy, the Council accepted the following district nominations for membership on the Board of Directors of Blue Shield, to fill vacancies occurring at the expiration of terms in March, 1955:

W. Lawrence Daves, Evansville—First District

Hubert T. Goodman, Terre Haute—Fifth District

E. H. Clauser, Muncie—Eighth District

R. R. Calvert, Lafayette—Ninth District

M. F. Miller, Fort Wayne—Twelfth District

On motion of Drs. Glock and Ross, the matter of appointment of physicians not from the districts was referred to the Council Reference Committee on Insurance.

11. *Spring meeting of the Council.* On motion of Drs. Ross and Dudding the Council voted to hold the spring meeting on Sunday, April 29, 1956, at the Indiana University Student Union Building, Indianapolis.

There being no further business, the meeting was adjourned.

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EXECUTIVE COMMITTEE

January 18, 1956

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser.. M.D.; W. U. Kennedy, M.D.; Elton R. Clarke, M.D.; O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump and Robert Hollowell, attorneys; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

Membership Report

Number of members January 18, 1956	1,163*
Number of members January 18, 1955	1,279
Loss over last year	96
Number of members December 31, 1955	3,967

* Includes 49 in military service (gratis)
47—$10.00 members (residents and interns)
116—senior members
35—members, dues remitted by Council

Number who have paid AMA dues:

January, 1956	960
January, 1955	1,055
Loss	95

Headquarters Office

The field secretaries reported on their activities for the preceding month.

On motion of Drs. Kennedy and Sicks the executive secretary and field secretaries were authorized to attend the Medical Society Executives Conference in Chicago, February 6, 7 and 8, 1956.

By consent it was agreed the executive secretary should arrange for a hospitality suite in the headquarters hotel for the June A.M.A. meeting in Chicago.

Statements of Receipts and Expenditures for December for the Association and THE JOURNAL were approved.

Legislative Matters

The secretary reported on the change in physician rank for those entering military service, as well as on HR 7225 and HR 7994.

1956 Annual Convention, Indianapolis, October 16-18, 1956

Attention of the Committee was called to the actions of the Council at its meeting on January 15, 1956, in which $8,000.00 was appropriated to the Local Arrangement Committee and $1,295.00 to the Scientific Exhibit Committee for the 1956 meeting.

1957 Annual Convention, French Lick

Upon motion of Drs. Clauser and Sicks the dates for the 1957 meeting at French Lick were set as October 6 through 10.

Organizaton Matters

Employees retirement fund. Upon motion of Drs. Kennedy and Sicks the New England Mutual Insurance Company was selected as the carrier for the employees retirement fund.

Kinescoping TV programs. On motion of Drs. Clarke and Clauser, the request of Dr. Olga Bonke Booher for a $50.00 contribution to the State Nutrition Council for the purpose of kinescoping television programs was approved.

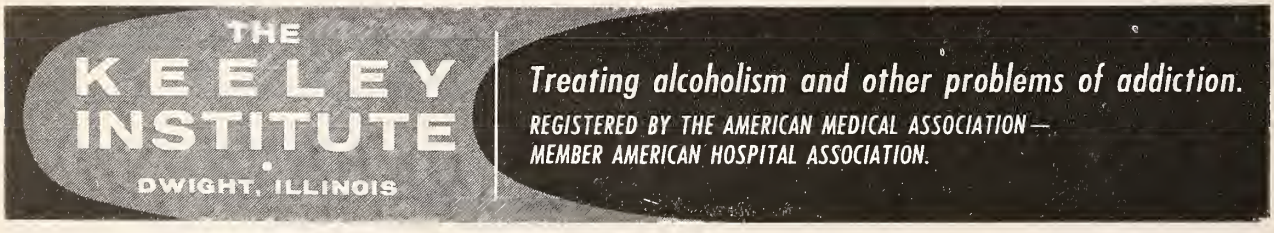
On motion of Drs. Clarke and Clauser, the secretary was instructed to place a page ad in the annual convention issue of the publication of the Hoosier State Press Association.

On motion of Drs. Sicks and Clarke, a request of the Indiana Division of the International College of Surgeons for use of the mailing list was approved.

On motion of Drs. Clark and Sicks, request of Norways Foundation to include a circular on the psychiatric seminar in the February issue of the News Flash was approved.

A letter from the Wells County Medical Society was referred back to the local society, upon motion of Drs. Clarke and Clauser.

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Request of the Northern Tri-State Postgraduate Medical Association for use of the mailing list was approved on motion of Drs. Clauser and Clarke.

Payment of dues in the amount of $75.00 in the Conference of Presidents was approved on motion of Drs. Clauser and Kennedy.

Upon motion of Drs. Kennedy and Clarke the Committee voted to discontinue subscription to the Shearon publication, "Challenge to Socialism."

The Journal

Report of advertising was approved by consent:

Total advertising, January, 1956	$3,168.79
Total advertising, January, 1955	2,997.88
Net gain	170.91

The secretary read a letter from the State Journal Advertising Bureau of the American Medical Association in which they had forwarded a dividend of $1,727.81 to the Association as profit on the operating expense of the Bureau. The secretary also read a notification and reported on the action of the House of Delegates of the A.M.A. at the Boston meeting in which the State Journal Advertising Bureau is to be completely separate from the American Medical Association as of February 1.

Future Meetings

By consent it was agreed that Dr. J. E. Dudding, chairman of the Committee on Rural Health, should attend the Eleventh National Rural Health Conference at Portland, Oregon, March 8-10, 1956.

By consent it was agreed that Dr. M. E. Glock, chairman of the Committee on Medical Education and Licensure, should represent the Association at the A.M.A. Conference on Medical Education and Licensure, February 11-13, 1956, in Chicago.

By consent the executive secretary was instructed to accept the invitation of the Blue Shield Commission to participate in their Public Relations Conference in Chicago February 16-18, 1956.

There being no further business the Committee adjourned to meet again at 2:30 p.m., Wednesday February 22, 1956, in the Student Union Building, I. U. Medical Center, Indianapolis.

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SURGERY—Surgical Technic, Two Weeks, April 2, April 16
Surgical Anatomy & Clinical Surgery, Two Weeks, June 18
Surgery of Colon & Rectum, One Week, April 9, May 7
General Surgery, Two Weeks, April 23
Basic Principles in General Surgery, Two Weeks, April 9
Thoracic Surgery, One Week, June 4
Esophageal Surgery, One Week, June 11
Breast & Thyroid Surgery, One Week, June 18
Gallbladder Surgery, Ten Hours, April 9, June 25
Fractures & Traumatic Surgery, Two Weeks, June 18
Varicose Veins, Ten Hours, April 30, June 18

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, April 16, June 18
Vaginal Approach to Pelvic Surgery, One Week, April 30, June 11

OBSTETRICS—General & Surgical Obstetrics, Two Weeks, May 7

MEDICINE—Internal Medicine, Two Weeks, May 7
Electrocardiography & Heart Disease, Two Week Basic Course, March 12
Gastroenterology, Two Weeks, April 23
Dermatology, Two Weeks, May 7

RADIOLOGY—Diagnostic X-Ray, Two Weeks, April 30
Clinical Uses of Radioisotopes, Two Weeks, May 7

PEDIATRICS—Intensive Review Course, Two Weeks, May 14
Neurological Diseases: Cerebral Palsy, Two Weeks, June 18

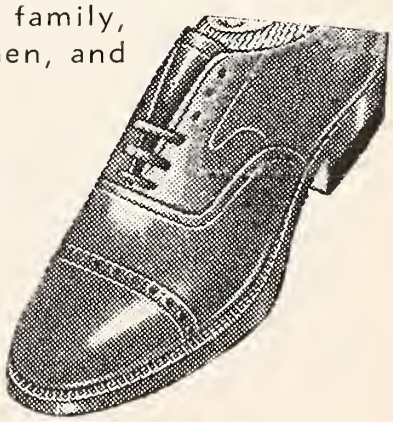
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News from the County Societies

Adams County Medical Society members met January 10 in the Fairway Restaurant, Decatur, at 5:30 for a business meeting and dinner. The 12 members present heard a discussion on "How a Credit Bureau Can Aid in Medical Collections." Later Dr. G. J. Kohne, Decatur, was elected chief of staff of Adams County Memorial hospital; Drs. John Carroll, James Burk and C. P. Hinchman, were named to the executive committee, and Dr. Robert L. Boze, Berne, secretary-treasurer. The February meeting was held in the Decatur Community Center February 14.

Twenty-seven members of **Bartholomew-Brown County Medical Society** heard Lt. Samuel Hucke (MC) discuss "Potentiality of Atomic Warfare in the World Today" at a meeting January 11 in Palm's Cafe, Columbus. A general discussion of the proposed government program to provide medical care for dependents of military personnel followed a routine business meeting.

Carroll County Medical Society met December 21 in the American Legion Home in Delphi with 8 members and 11 guests present for the dinner meeting and election of officers for 1956.

On January 18 Carroll county doctors and their guests heard Dr. Donald K. Winter, Logansport, speak on "Music in Medicine." This meeting was also held in the Legion Home. Plans were formulated for the examination of all doctors in the county by their fellow physicians.

"The Days Ahead" was the topic of a talk given by Marvin Schultz, Blue Cross representative, before the **Cass County Medical Society** at a dinner meeting in Ben Hur Restaurant, Logansport, January 16.

Reports were made by Drs. Killian, Hall and Hillis. Thirty-one members and V. C. Panarisi of Blue Cross, a special guest, attended the meeting.

Dr. F. B. Kantzer, Garrett, was the speaker at a meeting of **DeKalb County Medical Society** members in Sanders General Hospital on January 10. The meeting was called for 9:30 p.m. to discuss several important business matters. Dr. Kantzer spoke on "Fixation of Medical Fees." Members were unanimous in opposing legislation to provide civilian care of families of service personnel. Eleven members of the society were present.

Fifteen members of the **Fayette-Franklin County Medical Society** attended a dinner meeting January 10 in the Connersville Country Club. Robert J. Amick, field secretary for ISMA, discussed action taken by the American Medical Association at its December meeting in Boston. The society voiced strong disapproval of the government proposals to prepay fully all medical care of military dependents.

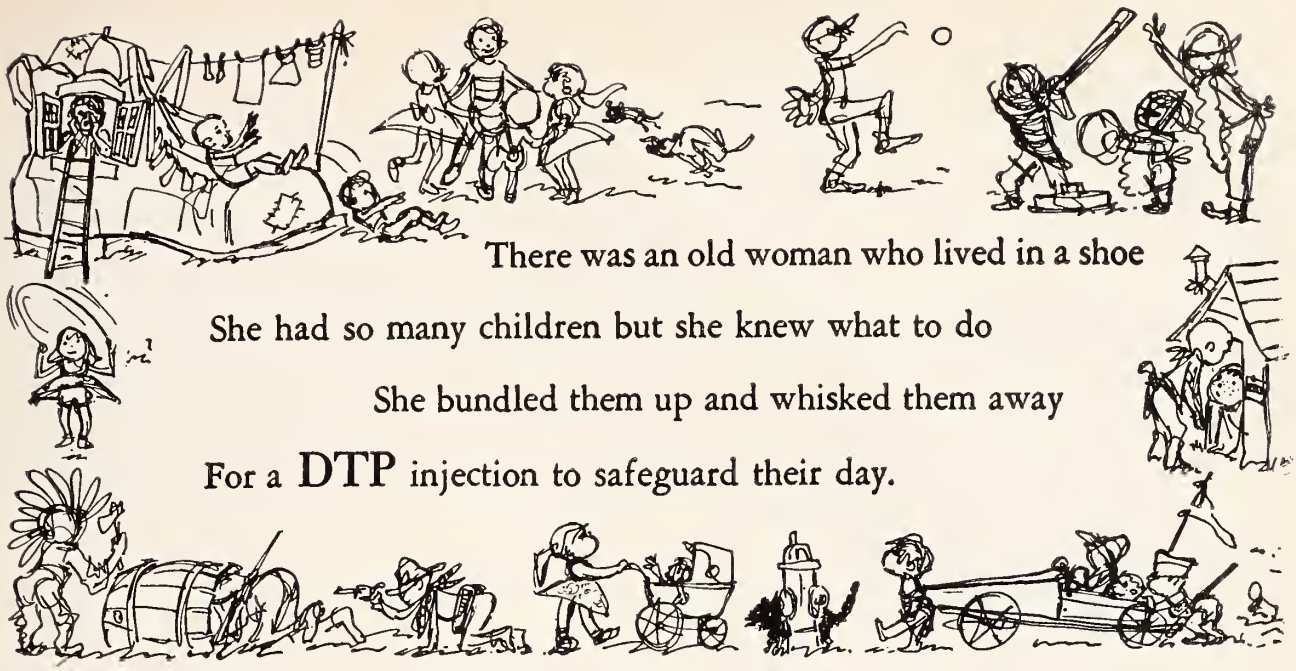
Dr. Paul P. Hess, New Albany, presented a paper on "Examination of the Newborn" at the January 13 meeting of **Floyd County Medical Society.** A film on the same topic was also shown.

During the business meeting several current pieces of legislation were discussed; the treasurer's report was read and accepted and a 1956 budget approved; and R. J. Amick, ISMA field secretary, spoke briefly on the AMA meeting in Boston. Twenty-five members attended the dinner meeting in New Albany Country Club.

Members of the **Fountain-Warren County Medical Society** met in the Attica hotel, Attica for dinner and a program February 2. A motion picture lecture on appendicitis by Dr. Joseph Brenneman, noted pediatrician, was presented. Nine members and one guest, Dr. P. E. Fishkorn, were present. A brief business meeting and discussion of matters of policy followed the program.

The next meeting was scheduled for March 1 when Dr. T. T. Suzuki, president of the society, and Mrs. Suzuki were to entertain members and their wives at dinner in the Suzuki home.

Ten members and five guests attended the January 11 meeting of the **Gibson County Medical Society** held in the Emerson Cafeteria,



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Princeton. Guest speaker was Dr. Albert Marshall of the Indiana State Board of Health who discussed the "St. Louis Encephalitis Epidemic" and also urged that blood samples be sent to the State Board of Health to determine the incidence of disease.

A general business meeting to consider several important local issues was held January 26 by **Grant County Medical Society** with approximately 50 doctors attending. The meeting followed a dinner in the Hostess House, Marion, with members of the Woman's Auxiliary attending. The Auxiliary met separately later.

Kenneth W. Bush, ISMA field secretary, spoke on some national legislation, the function of the Medical Defense committee, and the field service.

Election of new officers was held. Dr. Max R. Long, Marion, was named president for 1956; Dr. Robert G. Young, Marion, vice-president; Russell W. Lavengood, Marion, reelected secretary-treasurer; Drs. Peter C. King, Swayzee, and George Daniels and Robert Brown, Marion, to the board of censors. Dr. Robert M. Brown was named delegate to ISMA, and Dr. John G. Rhorer, alternate.

Dr. J. A. Graf, Bloomfield, presented an interesting clinical case report to members of the **Greene County Medical Society** who met in the Freeman Greene County Hospital, Linton, on January 12 for dinner. Fifteen members and R. J. Amick, ISMA field secretary, attended. At the business meeting which followed Dr. Graf's talk, Mr. Amick made a comprehensive report of action and proposals at both state and federal levels. Committees for the year were also appointed.

Hancock County Medical Society met January 24 in the Hancock County Memorial Hospital, Greenfield, for dinner with 14 members attending. The guest speaker, the Reverend Mr. Arthur, pastor of Greenfield Presbyterian church, talked on "Being."

At a brief business meeting the group set up the organization for a fund to aid in nurse education.



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Pictures taken at the special **Huntington County Medical Society** meeting honoring Dr. Claude S. Black, Warren, show; left to right: Dr. George R. Daniels, Marion, also a past president of ISMA; Dr. Mark G. Erehart, Huntington; Dr. Black, who had completed 50 years of practice and also served as president of his county, district and state medical organizations; Mrs. Black; Dr. Merrill S. Davis, Marion, with whom Dr. Black served during World War I; Dr. Wallace S. Grayston, Huntington county's only other physician who has practiced for 50 years; and Dr. Truman E. Caylor, Bluffton.

At top, right, Dr. Elton R. Clarke, Kokomo, presents bouquet of roses to the guest of honor; and below, Dr. Black speaks at close of meeting, recounting personal experiences and expressing his appreciation for the tribute paid him.

Dr. Claude Black Honored by Fellow M.D.'s for Long Service

At a special meeting of Huntington County Medical Society on December 13 Dr. Claude S. Black, Warren physician for 50 years, was honored by his Huntington county colleagues and their wives and several other special guests. A dinner in his honor in the Hotel LaFontaine, Huntington, was attended by 70 guests. Several old friends of Dr. and Mrs. Black including Dr. and Mrs. Truman Caylor, Bluffton, Dr. and Mrs. Merrill Davis, Dr. and Mrs. Richard Davis, and Dr. Joseph Davis, all of Marion, and Dr. and Mrs. George Daniels, Marion, were present. Dr. Elton R. Clarke, Kokomo, president-elect of ISMA, and Mrs. Clark represented the state association.

Dr. Black's entire life has been closely associated with Huntington county where he was born 75 years ago and received his secondary education. After his 1905 graduation from the Indiana College of Medicine he immediately established his practice in Warren where he is still active. He served during World War I at Fort Sam Houston, Texas. During his 50-year career in medicine, Dr. Black has been Huntington County Medical Society president, president of his district medical society and in 1950 climaxed his service by being elected president of the Indiana State Medical Association.

Several guests spoke informally at the dinner. Gift presentations were made by Dr. Elton R. Clarke who presented a bouquet of 50 roses on behalf of the state association; Dr. S. E. Cope, president of the host society, who gave Dr. Black a smoking stand; Dr. Paul M. Gray, who presented him a book autographed by each member of Huntington County Medical Society with personal comments by many. A desk set from the Huntington County Hospital Nurses Alumnae Association was among other gifts received.

Other special guests at the dinner were Miss Suzanne Black, daughter of the honored guest; Mrs. Lucien Smith, Drs. Eleanor E. and Robert E. McIlwaine, Warren, Mrs. Lawrence Webb, Warren, and Kenneth W. Bush, ISMA field secretary.

Fifteen members of **Hendricks County Medical Society** and Auxiliary attended a noon luncheon meeting in the O. K. Restaurant, Danville, on January 10. After discussion, the society expressed its position on several matters of policy. There was general discussion of the county hospital project.

Dr. M. O. Scamahorn, Pittsboro, was named secretary for 1956.

Henry County Medical Society held two meetings in January, the first a called meeting to discuss business and society policy. The meeting was held at 8:30 a.m. in the Henry County Hospital.

The regular meeting of the society on January 19 was also held in the hospital. Twenty-one members attended, heard a recording on "Backache" by Dr. George J. Garceau, Indianapolis orthopedic surgeon; discussed fee schedules; and voted to purchase a tape recorder for use by the society and its members.

Dr. E. Wade Adams, Fort Wayne, was the guest speaker at the January 3 meeting of **Huntington County Medical Society** in the Moose Lodge home. Following dinner, Dr. Adams presented a paper on "The Newer Pediatric Diseases." Fifteen members and two guests attended.

Members of **Johnson County Medical Society** heard a state drug store inspector explain various methods used by narcotics addicts to obtain drugs from doctors and druggists. George Gilbert, a registered pharmacist, emphasized the need for extreme care in writing and filling narcotics prescriptions.

A business meeting followed during which hospital affairs were discussed; the society agreed to assist the Auxiliary in planning a Health Day program in Johnson County; and opposition was voiced to several federal legislative proposals in the health field. Twenty-three members were present for the evening meeting in Johnson County Memorial Hospital, Franklin. R. J. Amick, ISMA field secretary, spoke briefly explaining some of the bills now under consideration in Congress.

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A dinner meeting of **Knox County Medical Society** was held January 17 in the Orchard Room of the Grand Hotel, Vincennes, with 15 members present.

Dr. Gordon T. Herrmann, Evansville, presented a paper on "Treatment and Prevention of Rheumatic Fever."

During the business meeting the society members voted to go on record as opposing any extension of federal medical and hospital care for dependents of military personnel.

The society scheduled a joint meeting with the Woman's Auxiliary for February 21 in the Vincennes Country Club.

The **LaPorte County Medical Society** met for dinner January 19 in the Spaulding Hotel, Michigan City, after which the 36 members attending elected officers; voted to alternate business and scientific meetings; discussed fee schedules; and voted to continue to sanction the Red Cross Blood Bank program.

The February 16 meeting of the society was to be held in the Hotel Rumely, LaPorte, with Dr. Samuel H. Leuscher, biochemist in research at the Argonne Research Laboratory, University of Chicago, scheduled to speak on "The Effect of Irradiation by Radioactive Materials" and also "Diagnosis and Therapeutic Effect by Radioactive Elements."

Business meetings of the **Miami County Medical Society** were held on December 30 and January 27 in Veach's Steak House, Peru, with nine members attending the first meeting and seven present for the January meeting. At the December meeting officers were elected and committees appointed; the disadvantages of social security for physicians were discussed; the special committee on fee schedules referred the matter back to the society with the recommendation that no definite action be taken; and the possibility of less frequent meetings was suggested. At the January meeting committee appointments were discussed.

Twenty-nine members of **Montgomery County Medical Society** met in Culver Union Hospital, Crawfordsville, on January 19 for a discussion of routine society affairs.

At the first meeting under the presidency of Dr. George Poolitsan, members of **Owen-Monroe County Medical Society** voted unanimously to support the local Blood Bank program. Concern was expressed because the quota of donors is endangered and members voted to donate blood personally at the February 1 visit of the Bloodmobile. Committees for the year were appointed and routine business affairs reported.

Dr. Hargis R. Bush, Cannelton, spoke on "Bone Lesions" at a February 7 meeting of the **Perry County Medical Society** in the Nursing Center, Cannelton. The members went on record as unanimously disapproving government plans for medical care of military dependents.

At the annual dinner given by members of **Shelby County Medical Society** for the Woman's Auxiliary, the group was entertained by a group of physicians who call their organization "The Medical Society Chamber Music and Choral Society of Lower Basin Street." They

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Preceding the dinner and entertainment in the Elks Club, Shelbyville, officers of the Medical Society for 1956 were installed and Major Hospital staff announcements were made. Dr. R. F. Whitcomb presented a case report at the staff meeting and a teleclinic on "Strep Infection" was heard by the society.

Officers installed for 1956 for the society were Dr. Norman Richard, president; Dr. R. W. Gehres, vice-president; Dr. Wilson L. Dalton, secretary-treasurer; and Dr. P. R. Tindall, delegate to ISMA.

Dr. V. Brown Scott was installed as chief of staff at Major Hospital.

The 20 members of the medical society accepted the transfer membership of Dr. Thomas Younan from Warrick County, and discussed hospital expansion plans.

Dr. H. R. Oberhill, member of the faculty of Northwestern University Medical School and Chicago neurosurgeon, was the guest speaker for the **Vanderburgh County Medical Society** meeting January 10 in the Pompeiian Room of the Hotel McCurdy, Evansville. His discussion was on "Early Diagnosis of Brain Tumors."

Dr. Michael J. Sweeney of Mead Johnson and Company, and Dr. John A. Antonnetti of Deaconess Hospital, Evansville, were elected to membership during the business meeting; an Auxiliary resolution asking adoption of a plan for periodic health examinations for physician members was referred to the Auxiliary Liaison committee; a report of Dr. L. E. Gaul, retiring president, was submitted; and Dr. William L. Daves was installed as president of the society for 1956.

Members of **Wabash County Medical Society** held a dinner meeting January 11 in the Wabash Cafeteria, Wabash, with 14 members present.

During the business meeting members discussed the medical care program for military dependents and distribution of polio vaccine.

Kenneth W. Bush, ISMA field secretary, spoke on several matters on the state and national level. He explained provisions of HR 7225, amending the Social Security Act; discussed the ISMA Medical Defense setup; and spoke on the proposal to organize medical assistants groups.

Dr. Jean T. Stoops, Wabash, is 1956 president of the society; and Dr. Vincent J. Hanneken, Wabash, is secretary-treasurer.

William Saunders, administrator for the new Monticello Hospital which is expected to open in the spring, gave a progress report to the 11 members of **White County Society** who attended a dinner meeting in the Sportsman Restaurant, Monticello, January 11. A general discussion of the plans for operation of the hospital followed.

Kenneth W. Bush, ISMA field secretary, discussed the recent survey on social security made among Indiana physicians; HR 7225 (the society endorsed the stand taken by AMA in opposition to the bill); medical defense provisions of ISMA; and the government proposal to expand medical care facilities for military dependents.

The White county physicians, who have been meeting on a quarterly basis, voted to hold a meeting each month.

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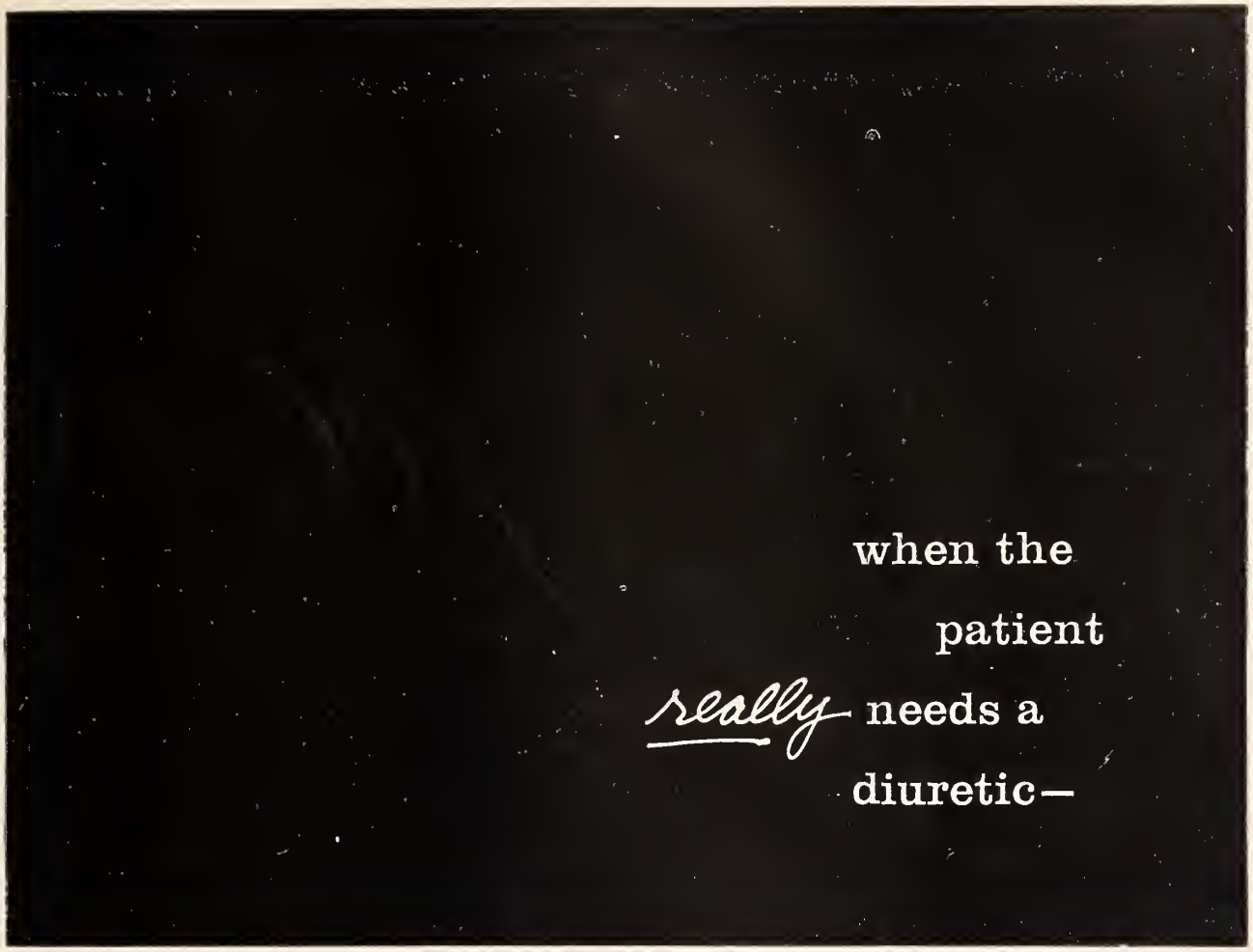
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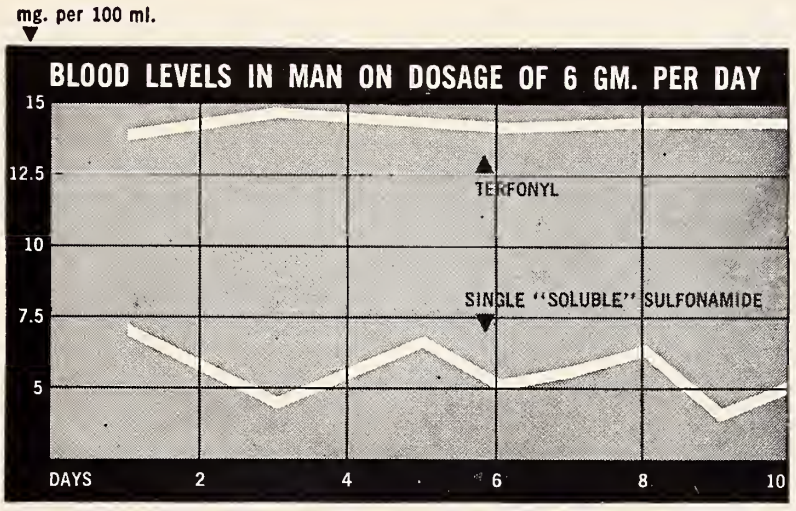
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No trichomonad escapes — The fast triple action of VAGISEC liquid dooms the trichomonad. Three surface-acting agents combine in synergistic attack,[1] to weaken the cell membrane, to remove waxes and lipid materials from the membrane surface, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

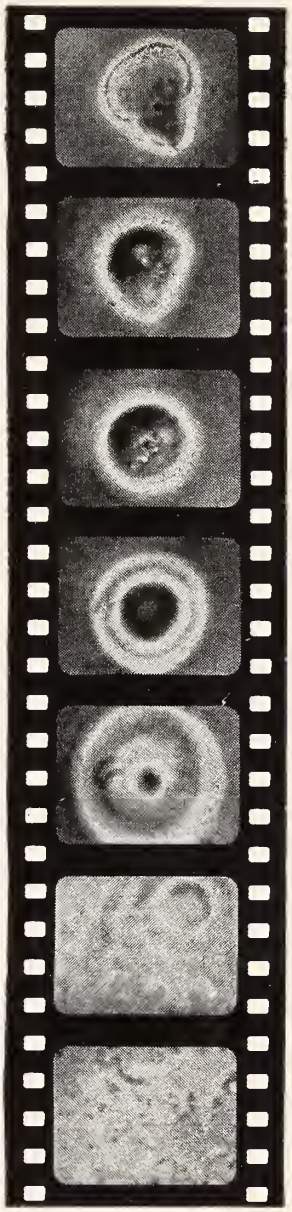
No other agent or combination of agents kills the trichomonad in this specific fashion or with the *speed* of VAGISEC liquid.[3] When the patient uses VAGISEC jelly as well — the recommended routine — these good effects continue indefinitely.[4]

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The Davis technique — Office therapy with VAGISEC liquid is combined with home treatment. Both liquid and jelly are prescribed.

OFFICE TREATMENT — *Wipe vaginal walls dry with cotton balls, then wash thoroughly for about three minutes with a 1:250 dilution of* VAGISEC *liquid. Remove excess fluid with cotton balls. Dr. Davis recommends three treatments the first week, two the second and one the third.*

HOME TREATMENT — *Patient douches with* VAGISEC *liquid at night and inserts* VAGISEC *jelly every morning except on office treatment days, through two menstrual periods. Douching is contraindicated for pregnant women.*



Top to bottom:
2 sec. CONTACTS
4 sec. COMPLEXES
6 sec. DISSOLVES
8 sec. DENATURES
10 sec. SWELLS
15 sec. EXPLODES
16 sec. SCATTERS

References: 1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. 3. Davis, C. H., and Grand, C. G.: Am. Jour. Obst. & Gynec. *68*:559 (Aug.) 1954. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, Md., W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33.

Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

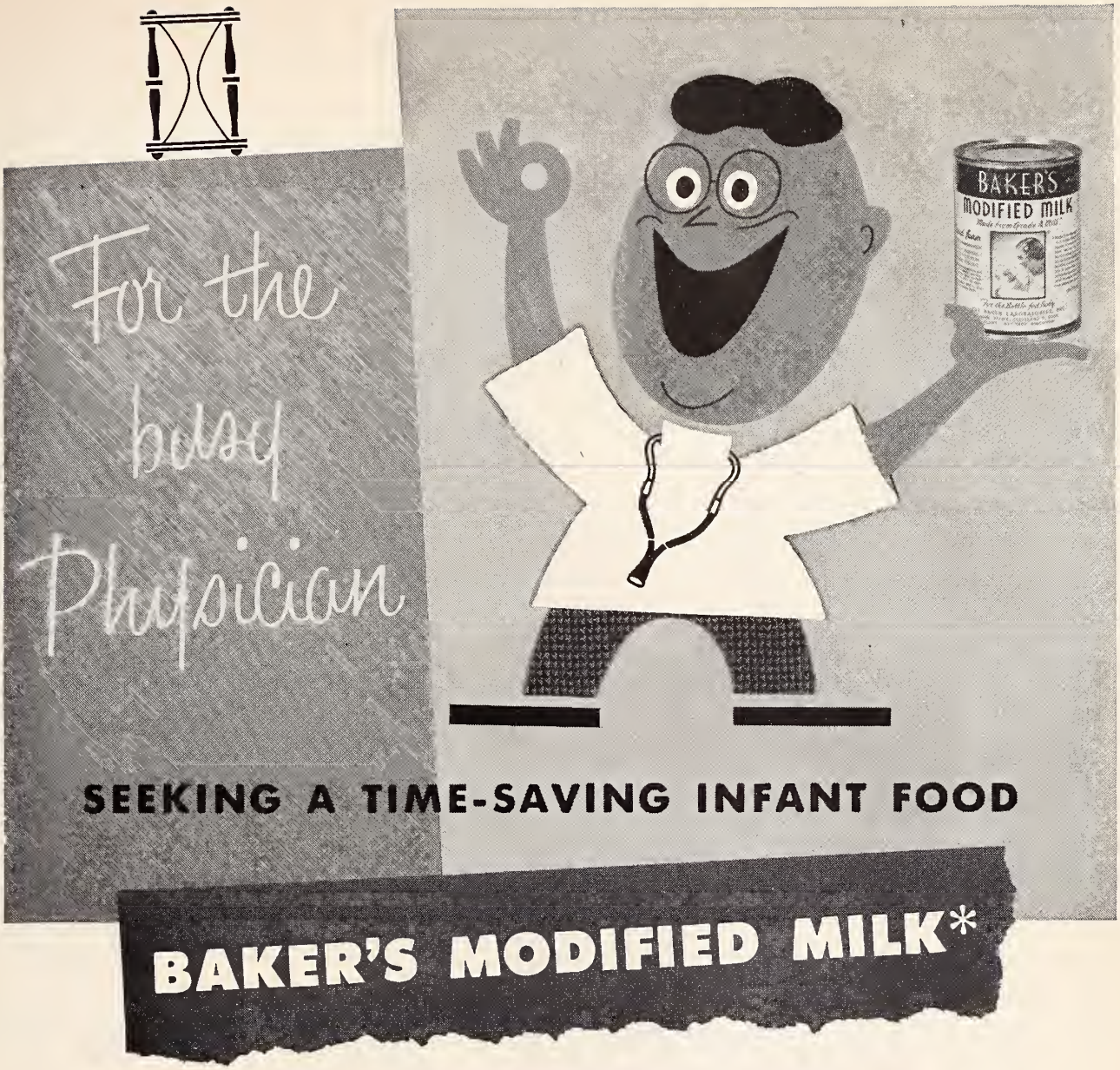
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Also available in powder form. (Normal dilution one tablespoon to 2 ounces of water provides 20 calories per fluid ounce.

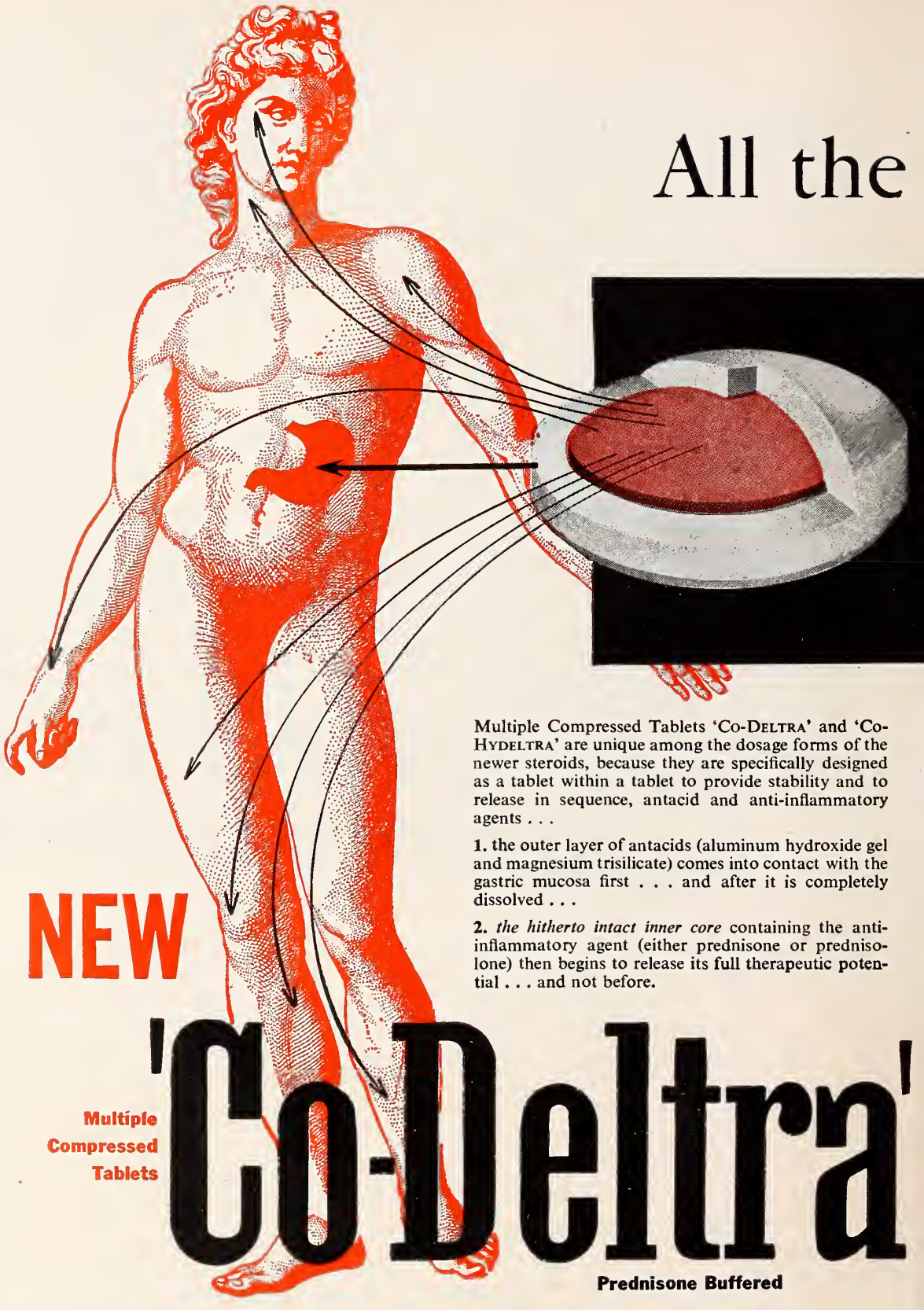
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1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* **158**: 459, June 11, 1955.

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C.—A little-publicized study group of eight physicians and scientists has submitted a report to the Secretary of Health, Education, and Welfare that promises to stimulate considerable debate by all interested in medical research, including members of Congress.

The committee was appointed by the National Science Foundation a year ago at the request of former HEW Secretary Hobby for "a critical review" of the scope and distribution of all phases of medical research where U. S. funds are used. Heading the committee was Dr. C. N. H. Long of the Yale School of Medicine.

Three basic proposals of the committee:

1. That research within the National Institutes of Health Research be levelled off, and policy and personnel matters there be brought under the scrutiny of an advisory board of non-governmental medical scientists.

2. That other research under the Public Health Service, including teaching grants to institutions and fellowships, be put under a new Office of Medical Research and Training reporting directly to the HEW Secretary and outside the control of PHS.

3. That emphasis be placed on general research rather than the present trend of specific grants for specific disease studies, the so-called categorical approach.

SUGGESTS NEW CONTROL

On receipt of the report, Secretary Folsom promised it would be studied "intensively" both by HEW and PHS officials, but he set no time deadlines.

The Long Committee noted the tremendous growth in federal medical research during and since World War II and the increasing role played by PHS. While conceding that PHS has done its job effectively, the committee felt that the time has come to re-examine the concentration of activities under one agency.

On its first point the committee said National Institute of Health is making a major contribution in medical research and that senior appointments there should actually become "the most sought after in the country." It suggested legislation that would permit employment of research scientists at the Institute without regard to commissioning in the PHS Corps or salary limitations imposed by Civil Service.

On its second basic proposal, the committee recommended that the new agency have authority over (a) unrestricted, long-term institutional grants, (b) grants for research, both categorical and non-categorical, (c) fellowships and traineeships in medical and related areas, and (d) grants for construction of research and teaching facilities.

Commenting on the categorical approach to research, the committee said the public has been "led to believe, consciously or unconsciously, that the donation of sufficient sums of money is all that is needed to eradicate diseases which have plagued mankind for centuries."

In Congress, any move away from categorical grants in medical research is certain to produce fireworks. Some Senators and Representatives believe it's Congress' responsibility to pinpoint where money it appropriates is to be spent, and they are not inclined to make an exception for research money.

EXPECT QUICK ACTION

Two bills on military medical legislation went through the House without change, after detailed hearings and study by a subcommittee. The expectation is that action on them will not be long delayed in the Senate.

One is designed to make military medical careers more attractive by allowing credit for



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for menopausal patients



comforts—Controls major symptoms within 6 to 10 days, hot flushes in as few as 3 days.

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*Clinton, M., Round Table Discussion: New York J. Med. *51*:481, 1951.
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time spent in medical school and internship, and setting up a series of three $50 per month raises after 3, 6 and 10 years' service. These would be in addition to the present $100 per month special pay for medical officers. Public Health Service medical officers would benefit, as well as those in Army, Navy and Air Force.

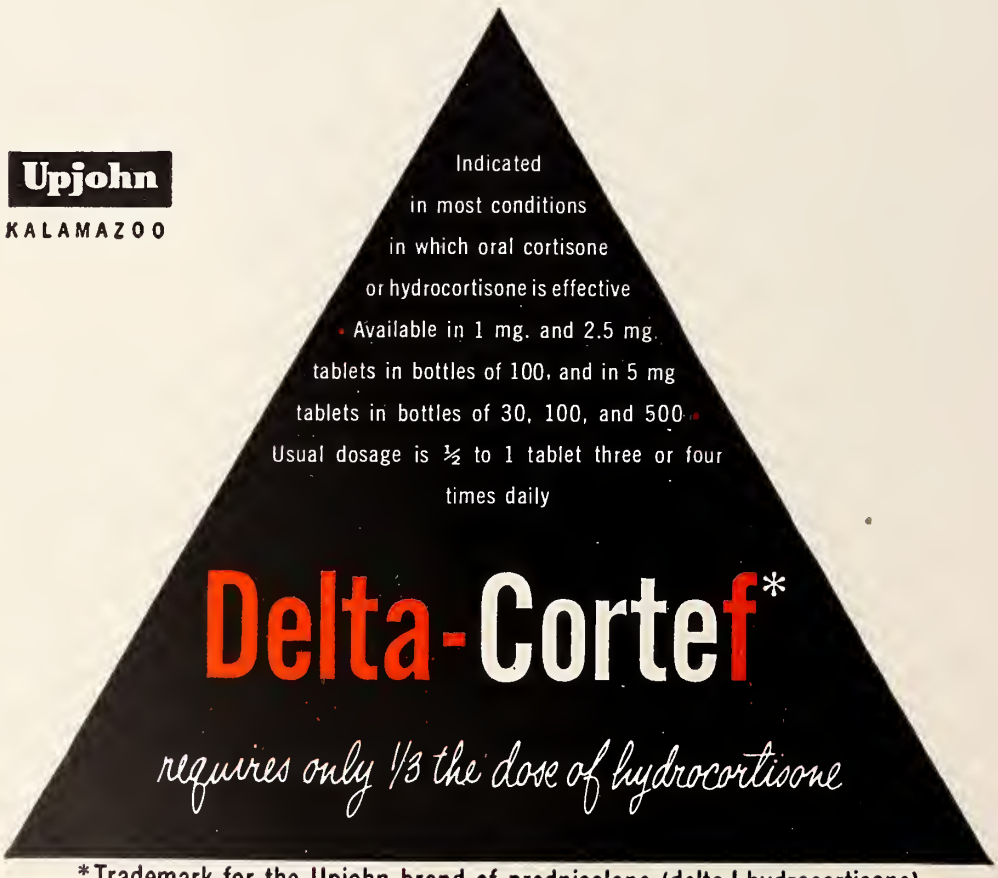
The other bill well on its way to becoming a law allows dependents of servicemen to receive private hospital and medical care, with the government paying the costs of the insurance or health plan coverage and the dependent the first $25 of the hospital bill. The Secretary of Defense, however, could limit or deny such private care in areas where he determines that military medical facilities are adequate to handle the service families.

NOTES

Some of the pharmaceutical houses have told Secretary Folsom that they plan to use more personnel and equipment to step up production of Salk vaccine, but his expectation still is that it will be "many months" before there will be enough vaccine for three shots for "all who need them".

Almost all medical programs handled by U. S. Public Health Service are virtually assured of comfortable increases in money for next fiscal year. The House approved recommendations of its Appropriations Committee without change. The only large reduction was $19 million in money for the Hill-Burton hospital construction program, the committee explaining this action was taken because the "new" HB program (for clinics, chronically ill hospitals, nursing homes, rehabilitation centers) is getting off to a slow start.

A new suggestion for helping to pay for medical care comes from Rep. Charles S. Gubser (R., Calif.). He is proposing that full income tax deductions be allowed for all medical expenses of children under six years of age.



*Trademark for the Upjohn brand of prednisolone (delta-1-hydrocortisone)



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The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

DON'T LET THE GUARD DOWN

A warning that Indiana is in danger of losing some of the priceless ground which has been gained in the fight against communicable diseases has been issued by the State Board of Health. An incidence of diphtheria sufficient to cause concern among health officials has occurred this winter in the LaPorte County area. A statement from the board asserts a belief that "under the right circumstances" it could occur in any Indiana community.

Diphtheria is a preventable disease. It is one which, like smallpox and whooping cough, has been almost wiped out in America by immunization.

Immunization, however, is effective only if it is maintained. The number of cases in the northern county in recent weeks is such as to suggest that the maintenance of immunization there has fallen to a level which invites an outbreak of the disease. If this is true in one county area, it may well be generally true.

The board's statement does not indicate that the situation is a cause for alarm. But it does indicate that it should be a cause of immediate concern, particularly for parents since diphtheria is particularly a peril of childhood and youth. The step to be taken is consultation with a physician, who can judge from the individual's immunization record whether a new shot is necessary. The medical procedure of preventing the disease is simple and effective.

The fact that diphtheria, smallpox and whooping cough seldom occur these days is no reason for letting down the guard against them. In theory it may be possible to eradicate these diseases entirely from the world, and forget them. But that can scarcely be accomplished in a lifetime, or even in several lifetimes.

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Books: Received and Reviewed

BOOKS RECEIVED

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

ATOPIC DERMATITIS. Symposium edited by Rudolf L. Baer, M.D., associate professor of dermatology and syphilology, New York University Postgraduate Medical School. 112 pp. Price $2.50. New York University Press, distributed by J. B. Lippincott Company, E. Washington Square, Philadelphia 5, Pa. 1955.

DISEASES OF THE LIVER. Edited by Leon Schiff, M.D., professor of clinical medicine, University of Cincinnati College of Medicine. 27 contributors. 738 pp., well illustrated. Price $16.00. J. B. Lippincott Company, E. Washington Square, Philadelphia 5, Pa. 1956.

HYPNOTIC SUGGESTION: Its Role in Psychoneurotic and Psychosomatic Disorders. S. J. Van Pelt, M.B., B.S., president, British Society of Medical Hypnotists. 95 pp. Price $2.75. Philosophical Library, 15 E. 40th St., New York 16, N. Y. 1956.

SHOULD THE PATIENT KNOW THE TRUTH? Edited by Samuel Standard, M.D., and Helmuth Nathan, M.D., 160 pp. Price $3.00. Springer Publishing Company, Inc., 44 E. 23rd St., New York 10, N. Y. 1956.

YOUR BLOOD PRESSURE AND HOW TO LIVE WITH IT. William A. Brams, M.D., associate professor of medicine emeritus, Northwestern University Medical School, and senior attending physician, Michael Reese Hospital, Chicago. 160 pp., illustrated. Price $2.95. J. B. Lippincott Company, E. Washington Square, Philadelphia 5, Pa. 1956.

DIAGNOSIS AND TREATMENT OF VASCULAR DISORDERS (Angiology). Edited by Saul S. Samuels, M.D., editor-in-chief, Angiology, and president, Angiology Research Foundation. 17 contributors. 621 pp., illustrated. Price $16.00. The Williams and Wilkens Company, Mt. Royal and Guilford Avenues, Baltimore 2, Md. 1956.

SURGICAL DIAGNOSIS. Philip Thorek, M.D., professor of surgery, Cook County Graduate School of Medicine, and clinical associate professor of surgery, University of Illinois College of Medicine. 320 pp., illustrated. Price $12.00. J. B. Lippincott Company, E. Washington Square, Philadelphia 5, Pa. 1956.

BOOKS REVIEWED

HANDBOOK OF PEDIATRICS. Henry K. Silver, M.D., Associate Professor of Pediatrics, Yale University School of Medicine; C. Henry Kempe, M.D., Assistant Professor of Pediatrics, University of California School of Medicine; and Henry B. Bruyn, M.D., Assistant Professor of Pediatrics and Medicine, University of California School of Medicine, and Assistant Clinical Professor of Pediatrics, Stanford University Medical School. 548 pp., handbook. Price $3.00. Lange Medical Publications, Los Altos, California. 1955.

The Handbook of Pediatrics offers a useful compendium for the busy pediatrician or general practitioner who sees children. The material is well written and up to date. The illustrations are helpful.

Extremely useful tables present various laboratory values, household poisons and their antidotes, recommended drug dosage for children, anticonvulsant drugs for children, and so forth.

Ailments are discussed, using a standardized format for etiology, clinical findings, complications and treatment. Drugs are also discussed with a standardized format, which makes for good organization and saves time.

The type is sufficiently large to be read without undue difficulty. The size of the book is excellent. The book is recommended for pediatricians and general practitioners who wish a condensed, readily available compendium.

The authors of this valuable book should have some recognition. It is unfortunate that the authors' names do not appear on the outside cover.

HAROLD D. LYNCH, M.D., Evansville.

GLANDULAR PHYSIOLOGY AND THERAPY. Prepared under the auspices of the Council on Pharmacy and Chemistry of the American Medical Association, Ed. 5 J. B. Lippincott Company, Philadelphia, 1954.

The Council on Pharmacy and Chemistry of the A.M.A. published the first edition of this work in 1924. At that time the physiology was fairly well defined but potent hormone preparations were few and therapy was generally irrational. The extensive endocrine research and development of rational endocrine therapy of the past 30 years has led to a demand for such a text as the present edition. This edition is a collaboration of 31 contributors, who are authorities in various areas of endocrinology.

The 22 chapter headings are: Integration of Endocrinology; (this is the least important chapter); The Adenohypophysis; The Hypophysis; Posterior Lobe; The Adrenal Cortex; The Adrenal Medulla; The Ovary; Physiology of Menstruation and Ovulation; Pregnancy and Lactation; The Testes; The Thyroid; The Parathyroid Glands; The Pancreas; The Thymus; Abnormalities of Body Weight; Endocrine Management of Neoplastic Diseases; (a very important chapter for surgeons); Abnormalities of Sexual Behavior; Therapeutic Uses of Cortisone and Corticotropin (ACTH) in Nonendocrine Conditions; Behavior and Intelligence; Common Misconceptions in Endocrine Therapy (very important); Diagnostic Aids; The Chemistry of Hormones; Modes of Administration of Hormones.

Much of the material concerns research work and may not appeal to the practicing physician, but therapeutic use of every known hormone is thoroughly discussed. Because of the nature of the material some portions of the work are not easy to read. The introductory chapter is somewhat difficult to read. It is written in very long sentences and foreign phrases are used which are not translated.

This colossal work contains over 2,000 references which is a complete bibliography on the subject of



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Smith, Kline & French Laboratories, Philadelphia

1. Howell, T.H., et al.: Practitioner *173*:172 (Aug.) 1954.

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

endocrinology. It is rare that such a wealth of authoritative information is found in one volume. The work should be available to every physician regardless of the branch of medicine he practices.

DAVID A. BICKEL, M.D., South Bend.

TEA, a Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea. Presented at a conference at the New York Academy of Sciences, May 16, 1955. Henry J. Klaunberg, Ph.D., Editor. The Biological Sciences Foundations, Ltd., Washington, D.C.

This little piece of 64 pages is one of the lesser jewels in the crown of science yet it has an especial interest for those who love the warmth and comfort of this beverage in winter, and its unexcelled virtues as a cooling, thirst-quenching "life-saver" in summer.

As the editor states in the preface, "although tea, next to water, is the most consumed beverage in the world, no serious effort has heretofore been made to organize the research and clinical literature on this subject for practical usage **(sic)** by individuals and organizations who have a professional interest in human nutrition and physical fitness".

In the introduction, S. O. Waife, M.D., F.A.C.P., editor of the American Journal of Clinical Nutrition, and Associate in Medicine, Indiana University School of Medicine, states: "It would seem that at present one can safely say that there are no medical contraindications to the drinking of tea (as ordinarily practiced) . . . To all intents and purposes tea has no caloric value (exclusive of any sugar or milk that may be added). Therefore it can be imbibed freely in obesity diets, . . . furthermore, there is no sodium in tea . . . In fact, there is scarcely a therapeutic diet in which tea could not be incorporated with impunity."

The main pharmacologic ingredients of tea are xanthines, chiefly caffeine, and tannins. Infused tea contains small quantities of riboflavin, nicotinic acid, pantothenic acid, and thiamin. The xanthines produce slight psychic stimulation and mild diuresis. The tannins contribute an astringency to the gastrointestinal tract and this may allay mild irritation. However, the experiments of Halpenny and MacDermot showed "that mixtures of caffeine and tannic acid modify the "pure" actions of each other." Many years ago Macht and Schroeder commented . . . that coffee, even in small quantities, had rather unpleasant effects on many people who suffered no such effects from tea. They then showed that "if caffeine were administered with adenin (which is present in tea), its effects were below the expected level". A most important variable "that may clearly modify the pharmacological effect of tea is the length of brewing. Three minutes after pouring boiling water on tea most of the caffeine has been extracted and the caffeine/tannin ratio is at its highest. A longer brewing adds progressively more tannin but little or no additional caffeine." Therefore, brewing longer than 4 or 5 minutes is considered undesirable. For those who **like** their tea brewed longer, the addition of milk counteracts the astringency of the excess tannin.

Wirts, Rehfuss, Snape and Swenson, of Philadelphia, studied tea with the following conclusions: "1. Tea appears to increase the rate of gastric emptying when compared to the effect of an equal amount of water when used with a 40% protein, carbohydrate, fat, or combined (eggnog) meal. 2). The iced beverages used have a more pronounced effect in this regard than hot. 3). Tea appears to stimulate gastric motility. 4). Tea, when compared to the effect of an equal amount of water, exerts approximately the same effect on the gastric secretory output (volume, pH, free acid, and pepsin)." Certainly, tea would seem inoffensive to the stomach.

In another section, Henry J. L. Marriott, M.A., B.M., Associate Professor of Medicine, University of Maryland School of Medicine, comes to the following felicitous conclusion: "Tea should be investigated in the form of its own inimitable infusion and not **qua** caffeine or any or all of its other components. The chemical mosaic that nature put together defies the strategems of the human analyst and, both anatomically and pharmacologically speaking there is undoubtedly more to this gentle beverage than meets the eye.

"Tea as a beverage was first mentioned in the literature as having been used by man as early as 2737 B.C. . . . tea has had a continuing universal and widespread appeal down to the present time. To what attribute does tea owe this unusual continued acceptance?" This question occurs in the section from the Department of Psychology, Brown University. "Twenty-two tea drinking subjects were run through a five-session cycle of tests to determine effects of drinking tea in a social situation . . . 1). Simple auditory reaction time was improved by tea, and the effect persisted through three test periods, the last of which was an hour and a quarter after tea. Complex reaction time to visual stimuli showed similar but smaller effect . . . Such improvement may be regarded as objective evidence that a cup of tea affords an immediate as well as a delayed "lift" without inducing secondary depressing effects in our subjects, under the conditions studied.

"2). Hand steadiness showed no significant gain or loss from tea. This is to be contrasted with the usual report of unsteadiness following caffeine.

"3). Tests for attention and strength of grip showed no clear effect after tea . . .

"4). Subjects' self-ratings of fatigue varied as expected, but differences between tea and no-tea days were not statistically significant."

Very refreshing, we think: if you like tea you can go right ahead drinking it with a clear conscience, and if you don't like it, you can still let your patients drink it—again with clarity of conscience. Neat,—not?

A. W. CAVINS, M.D., Terre Haute.

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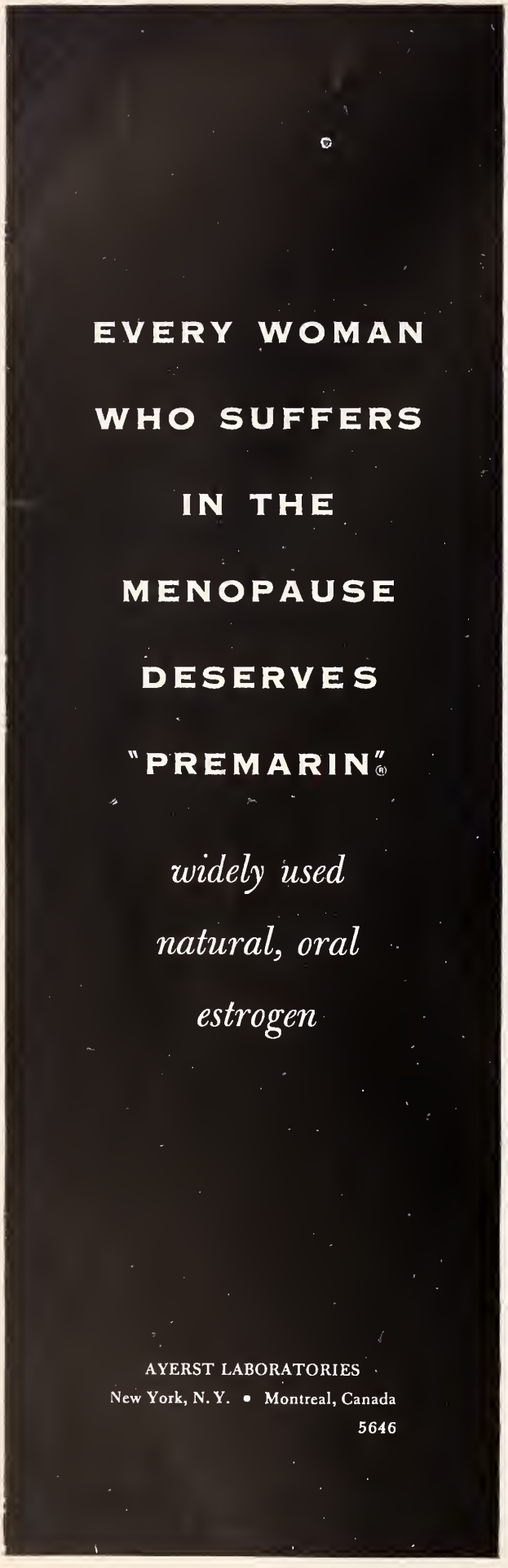
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A.M.A. Issues Booklets on Problem of Job Absence

Keeping Joe Worker healthy and on the job is a major problem facing both physicians and industrial leaders. Two new publications dealing with the problem of work absence have been prepared by the AMA's Committee on Medical Care for Industrial Workers—a joint committee of the Councils on Medical Service and Industrial Health. The first—a reprint from the January, 1956, issue of AMA *Archives of Industrial Health*—was prepared for the committee by Mark S. Blumberg, M. D. and James A. Coffin of the USPHS's Occupational Health Program. Entitled "A Syllabus on Work Absence," this booklet contains basic information for evaluating much of the data already published in this field.

The second pamphlet, "Company Medical Programs and Work Absence—10 Case Studies," discusses the medical programs of 10 companies and how they deal with non-occupational job absence. In addition to a brief description and history of each program, the booklet includes information on medical facilities and personnel, diagnostic aids and in-plant services, the problem of absenteeism, costs and benefits of medical department functions, and relationships existing between the medical department and the private practitioner.

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A.M.A. Plans Outstanding Program for 105th Annual Meeting in Chicago

PLANS ARE TAKING SHAPE for the AMA's 105th Meeting June 11-15 in Chicago. AMA has lined up nearly five full days of lectures, scientific and technical exhibits, color television and motion picture presentations to give physicians a good "short course" in post-graduate medical education. Between 12,000 and 15,000 physicians are expected to attend the convention which will center its activities at Navy Pier, Northwestern University, and near north side hotels. Headquarters for the House of Delegates will be at the Palmer House.

Some 350 technical exhibits and more than 300 scientific exhibits will be on display all week for the benefit of physicians and guests. The exhibit hall will be open "for doctors only" probably on Wednesday and Thursday mornings.

A few outstanding scientific features already scheduled include: fracture and fresh pathology exhibits; physical examinations for physicians; exhibit-symposiums on traffic accidents and arthritis and rheumatism; special exhibits on cardiovascular diseases and pulmonary function tests.

Physicians should begin now to make plans to attend this worthwhile medical meeting. More details will be published in the *Journal of the AMA*.

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Clinically Important Facts About Cancer Morbidity

Cancer statistics applied to the physical examination*

ALVIN S. CRAWFORD, M.D.

Indianapolis

THE BUSY PRACTITIONER may miss many important statistical studies relating to cancer (and other conditions) which often appear in journals with limited circulations. For this reason it seems worth while to bring those statistics together for an appraisal of their clinical significance and application. Such statistics are most significant when appraised along with other studies. For example, it is sometimes of value to compare regional studies within the United States or to compare material obtained in the United States with that from other countries. Many particularly important studies have appeared in the medical literature in the past few years. Interpretation and comparison bring out many interesting and clinically important facts of value to the physician who sees a large number of patients each day.

In the total of 1,500,000 deaths reported in the United States in 1952, slightly over 223,000 were reported as due to malignant diseases. This means that approximately 15 per cent of the deaths were due to cancer of some type. It has been estimated that if correct diagnosis were made this number might well be doubled. No doubt, a significant percentage of these could have been cured (or the individual's productive life prolonged) if all of these patients had sought a routine physical examination or earlier medical care when first symptoms appeared.

In the past few years a serious attempt has been made to educate the public to seek regular medical examinations. Fear of cancer is often the most powerful underlying motivation in those who actually follow this practice regularly.

* From the Department of Pathology, Indiana University Medical Center, Indianapolis, Indiana.

Because of this, the clinician sees people from the older age group—the group in which most cancer occurs with the highest incidence—for routine examination. For this reason, it would seem practical for the physician to follow at some time during the physical examination some definite routine specific search for cancer. Such a scheme based on cancer incidence statistics is presented in this paper.

The busy practitioner in particular must become proficient in budgeting time in his office in order to produce the most medical care for the greatest number of people. Armed with certain information as to the likelihood of disease in his locality and in his type of practice, general incidence and sites of predilection, he can make such decisions much more accurately and effectively. Cancer incidence statistics show that the practitioner who sees both white and colored patients must keep in mind two somewhat different concepts as to sites of predilection in the two races. Thus, in the white male, examination of lesions of the skin of the face, head and neck is extremely important, whereas it is not nearly so important in the colored male because of the tremendous difference in the incidence of cancer of the skin in the two races. On the other hand, cancer of the prostate gland has a significantly higher incidence in the colored male. The importance of knowing these facts is immediately apparent.

GENERAL INCIDENCE DATA

Information concerning the ocurrence of cancer is available from many sources. One valuable source is a recent Public Health Monograph by Dorn and Cutler[1] analyzing results of a one-year study of 10 large cities in different parts of the United States and representing incidence of cancer in a sample population of about 14,600,000 people. The incidence figures given herein are taken in large part from that study. However, numerous smaller studies have provided significant information and their value must not be discounted. The true picture is sometimes confused by "off-the-cuff" quotations and by misinterpretations which appear in daily newspapers and popular lay magazines.

The *annual incidence rate* refers to the number of cases of a given cancer diagnosed *per year* per 100,000 general population. This is the most important figure to the clinician because it gives a picture which can be related to the patients who pass through his office each day and each year. The overall picture shows that if incidence figures are age-adjusted with relation to the total population of the United States there is virtually no difference between the total incidence of cancer in males and females (males 331; females 330). However, division into sites of origin shows a marked variation in incidence, so that different parts of the physical examination and x-ray examination must be emphasized in the two sexes. Also, different areas must be emphasized in the nonwhite patient as compared to the white patient.

THE WHITE FEMALE PATIENT

The most common cancers in the white female patient (all white females considered) are listed in order of frequency in Table I. These figures show that by examining four readily accessible sites in the white female, (namely, breast, vagina and cervix, skin, and rectum) one can account for about 50 per cent of the incidence of cancer in this group. If, in addition, the stomach and colon is examined by x-ray, this figure is increased to about 70 per cent. In general, other less accessible areas are the sites of the remainder of cancers in white females.

TABLE I. THE WHITE FEMALE PATIENT

SITE	ANNUAL INCIDENCE (cases per 100,000 pop.)
DIGESTIVE SYSTEM	80
(Includes gastrointestinal tract, liver, biliary passages and pancreas)	
Rectum	15
BREAST	73
GENITAL ORGANS	74
Uterine cervix	39.1
Uterine corpus	16.8
Uterus, other locations	.4
Ovary	14.7
Vagina, vulva	3.0
SKIN	40
	267

Yearly incidence of most frequently occurring cancer in *white females* in U.S. (total annual incidence: 333). (Adapted from Dorn, H. F. & Cutler, S. J.: Public Health Monograph No. 29, 1955.)

THE NONWHITE FEMALE PATIENT

Many series point out the statistical difference in the occurrence of cancer in white and nonwhite females.[1] The incidences of the most

frequently-occurring cancers in the nonwhite female are listed in Table II.

Comparison of Tables I and II shows that cancer of the cervix is twice as common in nonwhite females as it is in white females. From a practical standpoint this emphasizes the need to take routine smears for cytologic study in all women, but particularly in Negro women. Cancer of the breast is second in incidence in nonwhite women but still makes up a large part of the total picture. Also, comparison of these two tables emphasizes the fact that cancer of the skin is relatively frequent in white women as compared with the Negro (both females and males). It follows that skin lesions of the face, head and neck are more likely to be malignant in the white female than in the Negro female.

TABLE II. THE NONWHITE FEMALE PATIENT

SITE	ANNUAL INCIDENCE (cases per 100,000 pop.)
GENITAL ORGANS	108
Uterine cervix	78.8
Uterine corpus	16.2
Uterus, other locations	.6
Ovary	9.9
Vagina, vulva	2.9
DIGESTIVE SYSTEM	68
Rectum	13.6
BREAST	54
SKIN	6
	236

Yearly incidence of most frequently occurring cancer in *nonwhite females* in U.S. (total annual incidence: 293). (Adapted from Dorn, H. F. & Cutler, S. J.: Public Health Monograph No. 29, 1955.)

PHYSICAL EXAMINATION OF THE FEMALE

In the search for cancer the parts of the physical examination to be emphasized in the female become obvious at once. Without altering one's habitual sequence in the examination certain parts can be given special attention. By allocating extra time to examine the breasts and the cervix in both white and nonwhite females over one-third of cancer in these persons can be discovered (that is, if biopsies are taken when indicated). About 70 per cent of new cases of cancer diagnosed in females arises in the genitals, breasts, or digestive system.

Breasts. The most common site of cancer in the breast is the upper outer quadrant with the region beneath the nipple second, then in order the upper inner quadrant, lower inner quadrant and lower outer quadrant.

The white female who has never been married has a significantly higher incidence of breast cancer than those who are or have been married (98 in never-married white females compared to 70 in others). This emphasizes that it is particularly important to examine the breasts of the well-preserved elderly spinster who may object rather strenuously to disrobing sufficiently for adequate examination. It is never safe to "watch" a suspicious breast lesion; it must be removed and examined microscopically when first discovered. The older the patient, the more important this practice becomes. A recent study[2] of 336 biopsies of breast nodules revealed 22.6 per cent to be malignant lesions; 76 per cent of the total number had been first detected within one month prior to biopsy. Assuming that the early part of the examination is the most thorough and unhurried, the breasts should be examined early in the routine. Examination should include the axilla and supraclavicular regions for possible enlarged lymph nodes. In examination of the breast itself, it is particularly important not to omit examination of the nipple and the breast tissue immediately underneath the nipple.

Genitalia. Both visual examination and bimanual examination are important. Vaginal smears for cytologic study should be a part of the routine female examination, and these should be made before the cervix is cleaned for visual examination. In patients with poor vaginal hygiene the unpleasant task of removing thick tenacious mucus from the external os of the cervix and from the fornices must be carried out because only after this has been done can the cervix be viewed satisfactorily. This is particularly important in nonwhite patients because of the high incidence of carcinoma of the cervix in those patients. Biopsies should be taken freely. In contrast with cancer of the breast, carcinoma of the cervix occurs much more often in married women than never-married women, but it occurs with a significant frequency in both. One should insist upon making this part of the examination even in the elderly unmarried patient if this can be done without complete loss of rapport. The bimanual examination must also be carried out with great care.

Digestive System. Because of the inaccessibility of all parts of the digestive system (except the rectum) to physical examination, more cases of cancer in this system are first diagnosed post-mortem than in any other system. The value of abdominal examination must not be minimized. Careful questioning may give a clue as to the need for x-ray examination. If a general x-ray survey is to be made, statistics indicate overwhelmingly that the gastrointestinal tract should be examined first.

The rectal examination is of prime importance and both the finger and the sigmoidoscope should be used. About 50-55 per cent of carcinoma of the large intestine and rectum are said to be within reach of the palpating finger. If the sigmoidoscope is used this percentage is increased appreciably.

Skin. The skin is the most easily examined organ of the body. Cancers of the skin are therefore accompanied by a higher percentage of early diagnosis and curative treatment. As pointed out previously, cancer of the skin in the colored races is relatively rare, but the incidence in the white race is high. The skin of the exposed areas of the body must be given particular attention because it is here that most cancer of the skin occurs. Cancer of the skin of the lower extremities occurs in white women with sufficient frequency to warrant special attention to any skin lesions in this area. Suspicious lesions must be excised or biopsy must be taken.

Malignant melanoma occurs much more often in whites than in nonwhites. It is slightly more common in white women than in white men. However, when it does occur in the Negro race the feet and legs appear to be sites of predilection; therefore, pigmented lesions in this region in Negroes should be regarded with suspicion.[3]

The above areas have been emphasized because they constitute such a great part of the total picture in cancer morbidity in the female. Again, the remainder of the physical examination must not be disregarded or minimized.

THE MALE PATIENT

Table III is presented to show the most frequently seen cancers in the white male. A glance at this table and comparison with those concerning females shows at once that more areas of high incidence of cancer are accessible to physical examination in the female than in the male. This is the reason that cancer is a much more fatal disease among men than among women, although the overall incidences in males and females are essentially the same.

TABLE III. THE WHITE MALE PATIENT

SITE	ANNUAL INCIDENCE (cases per 100,000 pop.)
DIGESTIVE SYSTEM	111
Rectum	22
SKIN	56
Face, Head and Neck	38.7
GENITAL ORGANS	39
Prostate	35
RESPIRATORY ORGANS	39
URINARY ORGANS	25
Urinary Bladder	18.6
BUCCAL CAVITY	21
	291

Yearly incidence of most frequently occurring cancer in *white males* in U. S. (total annual incidence: 338). (Adapted from Dorn, H. F. & Cutler, S. J.: Public Health Monograph No. 29, 1955.)

General physical examination, including examination of the skin, mouth, tongue and throat, and rectal examination both digitally and by sigmoidoscope will detect about one-third of cancer in males. Well over another third can be accounted for by x-ray examination of the lungs and the stomach and colon. Therefore, x-ray examination in the routine survey of the male patient is very important.

Special attention must be given to the search for skin lesions in the white male. This is particularly true for the skin of the head and neck and face.

If the digestive system is divided into its anatomical parts as to incidence for each organ and each part of the gastrointestinal tract, then cancer of the skin of the face, head and neck becomes the area of highest incidence of cancer in the white male. However, a large part of this is basal cell carcinoma which does not usually metastasize, but does invade and may involve important structures; therefore, these should be surgically excised and examined microscopically. A few cases of widespread metastases from such lesions have been reported.[4]

Next in frequency comes carcinoma of the prostate. This together with carcinoma of the rectum accounts for an incidence in the white male of 61 cases per 100,000 white males per

year in the U. S. This is about one-fifth of the cancer incidence in the white male. On this basis the rectal examination (including digital and sigmoidoscopic examination) might justifiably occupy a large amount of the time required for the physical examination. *This must not be a cursory examination.* It should be remembered that small papillary adenomas of the rectum are sometimes soft and velvety and are felt only by vary careful digital examination.[5] In a recent evaluation of 20,847 sigmoidoscopic examinations in asymptomatic patients, 7.68 per cent of men over 40 had polyps; 6.3 per cent of men over 40 had polyps showing malignant change.[6] Five-year cures are reported in about one-third of the cases of carcinoma of the rectum. In ideal cases such as small lesions found during routine examinations, the five-year cure rate may be as high as 70 per cent.[7] Thus, the rectal lesion found early is far from hopeless.

TABLE IV. THE NONWHITE MALE PATIENT

SITE	ANNUAL INCIDENCE (cases per 100,000 pop.)
DIGESTIVE SYSTEM	97
Rectum	12.7
GENITAL ORGANS	54
Prostate	50
RESPIRATORY ORGANS	33
URINARY ORGANS	12
Urinary Bladder	7
BUCCAL CAVITY	11
SKIN	5
	212

Yearly incidence of most frequently occurring cancer in *nonwhite males* in U.S. (total annual incidence: 253). (Adapted from Dorn, H. F. & Cutler, S. J.: Public Health Monograph No. 29, 1955.)

The figures shown in Table III concerning the incidence of cancer of the digestive system deal largely with the incidence in the gastrointestinal tract: namely, esophagus, stomach, small intestine, large intestine and rectum. For both the white and the nonwhite male it becomes obvious that a thorough x-ray examination of the gastrointestinal tract is extremely important.

Reference to Table IV shows the rather high incidence of genital cancer in the nonwhite male, most of which is due to carcinoma of the prostate. The rectal examination in this group of patients, therefore, takes on added importance.

Routine chest x-ray appears to be important in all male patients. (Not to be overlooked at this point is the possibility of detecting early unsuspected pulmonary tuberculous lesions.) From the standpoint of cancer, this is a much more important procedure in males than in females because carcinoma of the bronchus is probably from five to eight times as frequent in all males as in all females. At present, about 12 of every 100 new cancers found in males in the U. S. are in the respiratory system.[1]

It follows then that for thorough workup of male patients in the search for cancer, not only a thorough physical examination but also certain X-ray examinations must be carried out. Economic factors may require the physician to be judicious regarding which x-rays should be taken first. In the white male the upper gastrointestinal tract, the lower gastrointestinal tract and the lungs carry about equal importance (in the absence of any symptoms). However, in the nonwhite male, the order should be as follows: first, upper gastrointestinal tract, then lower gastrointestinal tract, then lungs.

SUMMARY

The incidence of cancer is discussed with a view toward application of these statistics to the routine examination and search for cancer by the busy practitioner. This is intended partially to point out the need for emphasis on different parts of the physical examination in males and females and in different races. It is not advocated that any part of the physical examination be omitted. However, the physician who has a high index of suspicion concerning certain diseases or areas is more likely to have a high percentage of accuracy in diagnosis. It is simply hoped that this information will provide a little additional help for those in whose offices the war against cancer must have its first line of defense.

It certainly is not intended to belittle the morbidity of degenerative diseases and infectious diseases, but rather to bring special attention to some facts about maligant diseases.

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WIDE SCALE CANCER SURVEY REPORTED

The largest cancer survey ever conducted in any country has been completed in 10 American metropolitan areas by the National Cancer Institute.

The survey, reported in the December 24 Journal of the American Medical Association, showed that "some progress" has been made in the management of the cancer problem.

There was a rise in incidence from 1937 to 1947, but it is difficult to determine the significance of this or to tell how much of the rise is "real," the report said.

"Improved techniques for diagnosis have resulted in the discovery of some cases that in the past would have been missed. The number of physicians with training and experience in diagnosis of cancer has also increased. Improved economic conditions in 1947 compared to 1937 may also have contributed. People are more likely to obtain adequate and specialized medical care during economic prosperity than during a depression period," the report said.

Cancer incidence, prevalence, and mortality rates were surveyed in 1937-39 and 1947-48 in Chicago, Detroit, Philadelphia, Pittsburgh, Atlanta, New Orleans, Dallas, Denver, San Francisco, and Birmingham, Ala.

The survey was on "a scale unrivaled in any other country" and could not have been undertaken without the support of state and county medical societies, the report said. Thousands of physicians contributed information concerning their patients.

"It is heartening to realize that such studies may be undertaken within the framework of the American system of medical care without breaching the traditional physician-patient relationship," the report said.

The survey showed that in 1947, 430 of every 100,000 residents had cancer at some time during the year—26 per cent more than in 1937, and 149 of every 100,000 died of cancer—an increase of 19 per cent. In 1947, 319 new cases were diagnosed for every 100,000 persons—30 per cent more than in 1937.

The survey also revealed that:

Thirty-two of every 100 newborn children may expect to develop cancer at some time during their lives, if present rates continue.

Of those 32, three may be expected to develop cancer by age 45, 14 by age 65, 23 by age 75, and the remainder in after years.

More than 500,000 new cases are being diagnosed in the United States each year. At current rates, cases may be expected to increase by more than 50 per cent in the next 25 years, since both total population and the proportion of older persons are expected to increase.

Making the report were John R. Heller, M.D., Sidney J. Cutler, M.A., and William M. Haenszel, M.A., Bethesda, Md., of the National Cancer Institute of the U. S. Public Health Service, Department of Health, Education, and Welfare.

Carcinoma of the Lung

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THERE HAS BEEN a marked increase in the rate of carcinoma of the lung. Forty years ago bronchogenic carcinoma represented 1.1 per cent of all cancer deaths, whereas at present it represents approximately 12 per cent of these deaths.[1, 2] The increased incidence may be both real and apparent. Undoubtedly, better diagnostic facilities have lessened the confusion with other respiratory diseases. There also is an increased life span of the general population, and thus more people are living to the cancer age. The increase of lung cancer has occurred principally in men. Approximately 24 per cent of all deaths from carcinoma in males are due to cancer of the lung in the age group between 45 and 60. The lung is the most frequent site of carcinoma in this group of our male population.[3]

A large amount of statistical information has been amassed in an effort to correlate the increased incidence of cigarette smoking with the increased incidence of cancer of the lung. Cigarette by-products have been carefully analyzed and the tars applied to animals in the experimental production of cancer.[4, 5] Whether or not these results are applicable to humans remains to be proved. There has been a much greater increase of lung cancer in men than in women, yet there has been an increase in smoking in both sexes. Statistics demonstrate that there probably has not been the increase in carcinoma of the larynx that there has been in carcinoma of the lung. Apparently the increase in bronchogenic carcinoma has been about the same in England as in the United States, but the rate of cigarette smoking in England has not increased as rapidly as it has in the United States.[2] As Berkson[6] pointed out, the figures of Doll and Hill[7, 8] in England were obtained from a survey of physicians and the statistics of Hammond and Dorn[9] on cancer and smoking were obtained by lay members of the American Cancer Society, and thus were weighted by definite selection. The results of the latter study, therefore, must be considered as presumptive and not that smoking necessarily is associated with, or the cause of, cancer of the lung. It seems paradoxical that in the survey the death rates for both cigarette smokers and non-cigarette smokers from all causes, including cancer of the lung, were lower than the official figures for United States white males. It also seems strange that the death rates for practically all diseases surveyed were higher in cigarette smokers than non-smokers, unless cigarette smoking aggravates all diseases. There is a paucity of direct evidence associating smoking and cancer, although recently some minimal epithelial changes have been reported in the respiratory tissue of smokers. As has occurred so frequently in the recent past, suggestive and presumptive evidence has been presented to lay organizations and the public, before such is proved or disproved, with considerable resultant psychological disturbance among the populace.

Atmospheric pollution, exhaust fumes of vehicles, and occupational hazards also have been cited as possible causes of the increased rate of bronchogenic carcinoma. There appears to be a greater incidence among urban residents than among the rural dwellers and benzopyrene has been suggested as the incriminating factor. The rate is increased apparently among workers in the uranium ore, chromate and asbestos industries.[2]

APPLIED PATHOLOGY

Several cell types of bronchogenic carcinoma exist and are of clinical importance. Squamous cell carcinoma with an incidence of approximately 40 per cent is the most frequent occurring type and is followed in order by large cell car-

cinoma with an incidence of 37 per cent, adenocarcinoma with 14 per cent, and small cell carcinoma with 9 per cent. The squamous cell and small cell varieties predominate in the male. The small cell and squamous cell carcinomas arise more centrally than the other types. The small cell variety is perhaps the most malignant. Cavitation is more prone to occur in squamous cell carcinoma. Squamous cell carcinoma occurs more frequently in older males, is usually slower in growth, and probably offers the best prognosis. The most frequent sites of metastasis outside of the involved hemithorax are the ipsilateral cervical and axillary lymph nodes. Other common sites are the liver, adrenals, bones, pancreas, kidney, brain and contralateral lung. Adenocarcinoma is the most frequent type found in females and usually occurs in the periphery of the lung.[10]

Bronchiolar carcinoma (alveolar cell carcinoma—pulmonary adenomatosis) is believed to arise in the more terminal bronchioles rather than in the more proximal bronchi which are the site of bronchogenic carcinoma. The tumor is characterized by its nodular infiltrative nature and tendency to spread slowly into various areas of the lungs. The alveoli are lined by cells of a columnar or cuboidal type which rarely destroy the pulmonary architecture. It resembles Jaagsiekte's disease in sheep. This neoplasm represents approximately 5 per cent of all lung cancers and appears about equally in men and women. Clinically, the tumor is slowly progressive and chronic and is operable only in its localized form.[11]

DIAGNOSIS

Any patient with a persistent cough, hemoptysis or wheezing deserves an adequate roentgenologic study and a bronchoscopic examination, if necessary, to clarify the diagnosis. Other suspicious symptoms are weight loss, thoracic pain, dyspnea and hoarseness. The latter may be due to involvement of the recurrent laryngeal nerve in the mediastinum by a tumor. Obstruction of the bronchi by a neoplasm may produce unilateral wheezing and secondary infection of the more peripheral area of the lung. Signs and symptoms of the infection may mask the primary lesion.

Carcinoma may be suspected in 75 to 80 per cent of cases by an adequate roentgenologic study. Planigraphic examination is often helpful in this connection. The roentgenologic manifestation may be that of an atelectasis of a segment, lobe or entire lung, depending upon the location of the obstructing lesion in the bronchial distribution (Fig. 1). An obstructive emphysema of the same respective distribution may be produced by a partial obstruction of the bronchus by the tumor which acts as a ball-valve. This valvular action permits air to enter the affected area of the lung but does not allow egress of air. The roentgenologic picture of the neoplasm may be that of a central hilar infiltrative mass or that of a peripheral irregular or circumscribed density. The appearance of an infiltrative lesion, usually associated with pneumonitis, is due to secondary infection of the lung distal to an obstructing lesion which interferes with drainage of the lung (Fig. 2). A small 1 to 2 cm. isolated nodule may be visualized or there may be a large, round, firm mass present (Figs. 3 and 4). A pleural effusion may partially obscure the underlying lung parenchyma.

Isolated pulmonary nodules or "coin" lesions are significant in that they represent a relatively high incidence of malignant and benign tumors that cannot be distinguished clinically from inflammatory processes. The incidence of carcinoma as found in various studies throughout the country ranges from 10 to 50 per cent, depending upon the age of the patient and the size of the lesion. The presence of calcium is not always a certain indication of benignity. Inasmuch as tuberculomas and granulomas are also frequently a menace to the patient, it is generally accepted that early surgical excision of these nodular lesions is indicated without entailing the risk of an increase in the lesion occurring during a period of prolonged observation.[12-15]

The presence of a pleural effusion in an older individual without other obvious explanation is suggestive of an underlying malignancy. A bloody effusion is strongly suspicious of carcinoma. The presence of malignant cells in the effusion is, of course, diagnostic. Bronchoscopic biopsy will produce a positive histologic diagnosis in some 30 to 40 per cent of the cases.[1] A strong suspicion can be gleaned from the appearance of the bronchial tree where there is deformity and fixation of the bronchi. Cytologic study of repeated sputum specimens, bronchial washings and Gelfoam wipings of the bronchial

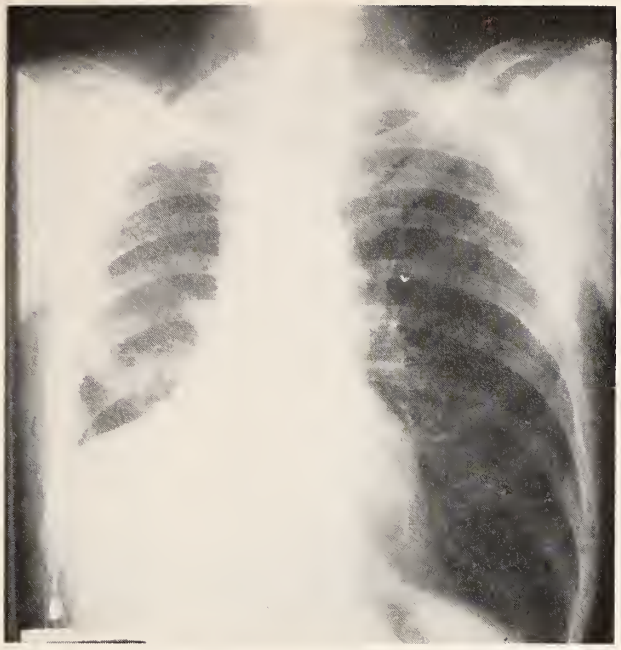


Fig. 1. Atelectasis of the right lower lobe due to bronchial obstruction by bronchogenic carcinoma.



Fig. 2. Pneumonitis in left upper lung resulting from impairment of drainage by the hilar neoplasm.

tree will bring the rate of histologically diagnosed cases up to 60 or 80 per cent, depending upon the experience of the pathologist and the adequacy of the specimens.[10, 16] Biopsy of the cervical nodes over the scalene muscles may confirm the diagnosis; however, the disease is incurable in such cases. Exploratory thoracotomy is necessary in 20 to 30 per cent of the cases in order to establish a histologic diagnosis.



Fig. 3. Typical "Coin" lesion which was removed and found to be a bronchogenic carcinoma.

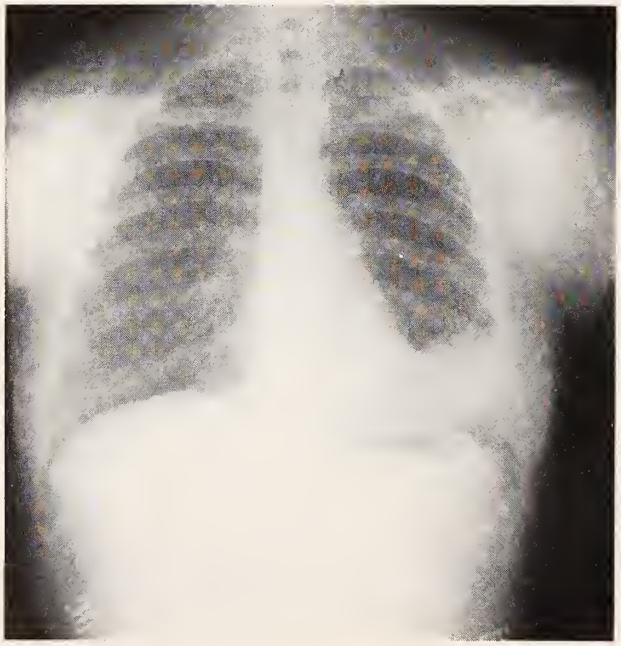


Fig. 4. Peripheral circumscribed mass in the left lower lung found to represent an adenocarcinoma in a young woman 21 years of age.

TREATMENT

Asymptomatic small peripheral lesions are most often resectable and offer the best prognosis. Miniature x-ray film surveys are of inestimable value in the detection of lesions of this type. The only known cure for pulmonary

carcinoma is the complete resection of the lesion. There is relatively little chance of cure for pulmonary carcinoma where there is a delay in treatment of over a year. Distant metatases to the peripheral lymph glands, central nervous system, subcutaneous and other such tissues are signs of inoperability. Likewise, evidence of local invasion of the vertebrae and the presence of malignant cells in the pleural fluid obviate surgical removal. The absence of malignant cells in a recently developed pleural effusion, however, should not prevent exploration. The presence of a Pancoast syndrome, due to the existence of an intrathoracic tumor located in the superior thoracic inlet, is a contraindication to surgical exploration, as it indicates irremovable tissue invasion.[17] This syndrome is characterized by pain in the shoulder and down the arm, Horner's syndrome, atrophy of the muscles of the hand, a homogeneous shadow over the apex of the lung, local rib destruction and vertebral infiltration. Involvement of the left recurrent laryngeal nerve is due to extension of the growth into or near the wall of the aorta with invasion of the mediastinum and is an indication of unresectability. There is only a limited hope in the presence of right recurrent laryngeal nerve paralysis.[18] Paralysis of the phrenic nerve is not necessarily a contraindication to exploration, as a local invasion of the pericardium can be excised in many instances. The prognosis is poor if there is local chest wall involvement including the ribs, however, in an occasional case it is feasible to excise the involved area together with the lung. Bronchoscopic findings of a markedly broadened carina due to involvement of the underlying glands or actual invasion of the tracheal wall lend considerable doubt as to the possibility of a cure.

Complete pneumonectomy with excision of the regional lymph nodes is the procedure indicated in the treatment of carcinoma of the lung. The resection must be considered palliative where there is extensive invasion of the mediastinal glands. The complete resection of localized extensions of the growth together with the lung offers hope of a cure. Such advances in thoracic surgery as the intrapericardial ligation of the vascular structures with partial excision of the pericardium and the plastic reconstruction of the tracheobronchial tree have extended the scope of surgery. Resection in the face of widespread mediastinal invasion and metastasis is hazardous and at best must be considered only palliative. The resection of a lung which is secondarily infected or abscessed, or where there is a strong possibility of such occurring, brings definite relief to the patient. A lobectomy may be performed in the occasional situation where there is an isolated peripheral lesion or a question regarding the cardio-respiratory reserve. There is a definite risk, however, of possibly leaving unremoved areas of more central lymphatic involvement. The best results are obtained where the lesion is confined within the lung with no evidence of regional lymph gland or other involvement. Serious consideration should be given to obliteration of the postoperative empty pleural space by a small tailoring thoracoplasty. The procedure is particularly indicated in individuals under 50 years of age when the prognosis appears to be good to prevent overdistention of the contralateral lung and development of hypertrophic emphysema. Pericardial phrenicectomy is also of value in reducing the size of the residual space.

When a lesion is found to be inoperable during exploratory thoracotomy, division of the sympathetic and vagal fibers supplying the bronchus and section of the intercostal nerves will relieve a great deal of the patient's later terminal pain and discomfort. Roentgen therapy may bring about arrest or recession of the growth in an occasional case of inoperable or non-resectable carcinoma of the lung. The most that can be hoped for in the majority of cases, however, is for some symptomatic relief. Roentgen therapy probably should be tried in most instances unless the patient is extremely ill or terminal. It probably has its greatest value in the resected case where it is believed that there may be some residuum. The instillation of radioactive gold salts or nitrogen mustard into the pleural cavity in cases of persistent pleural effusion is of considerable value in reducing the effusion. They may be used in conjunction with roentgen therapy. Nitrogen mustard is the more practical and safer agent to administer.[19]

RESULTS

A study of results reported from clinics or by groups of surgeons[1, 2, 10, 16, 18, 20] reveals that in general only 50 to 60 per cent of patients seen are considered operable and subjected to exploration. Of those explored, only 50 to 60

per cent are found to have a resectable lesion, or in other words only 25 to 30 per cent of all patients suffering from bronchogenic carcinoma are found to have a resectable tumor. Over half of the resections are thought to be of a palliative nature. The average operative mortality rate appears to fall between 15 and 20 per cent. The rate is higher in those cases where resection is carried out, particularly where the tumor involves adjacent structure, than in those subjected only to exploration. This figure has no doubt improved over the last five years. The 5 year survival rate in the resectable cases appears to be approximately 20 per cent. If, however, those cases for which palliative resection is performed are excluded, the 5 year survival rate is approximately 40 per cent. It has been further shown that the 5 year survival rate is not much less than the 2 year survival rate.

The author's private patient files for the past 10 years contained 204 cases of carcinoma of the lung, of which 160 were sufficiently documented for study. A review disclosed that 55.6 per cent of the patients were subjected to operation. The tumor was found to be resectable in 51.6 per cent of those explored. The total operative mortality was 12.3 per cent. The 2 year survival rate in the resected cases was 32.2 per cent. (No attempt was made to distinguish between palliative and curative resection.) The 5 year survival rate appeared to be about the same. The number traceable in the latter group, however, was insufficient to be statistically significant.

CONCLUSION

The greatest hope in the near future for further improvement in the results for carcinoma of the lung is in earlier detection and removal of the neoplasm while it is still confined within the lung.

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The Diagnosis and Treatment of Intraepithelial Carcinoma of the Cervix*

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THIS REPORT is based upon the experience at the Indiana University Medical Center from 1950-1955, with the diagnosis and management of 32 proven cases of intraepithelial carcinoma of the cervix.

Squamous cell carcinoma of the uterine cervix begins in the cells of the surface epithelium of the cervix, most frequently at the junction of the squamous and columnar epithelium. It remains a surface epithelial lesion for a period of several years or more before the cancer cells invade the subepithelial tissues and spread through the lymphatics of the cervix and paracervical lymph channels. During the period of years in which only the surface cells of the cervix are involved, the lesion is called an intraepithelial carcinoma (carcinoma *in situ*, preinvasive carcinoma). By cytologic cervical and vaginal smears and cervical biopsies, the diagnosis of intraepithelial carcinoma of the cervix can be established. The institution of adequate treatment should ensure a cure in each case.

Yearly pelvic examinations performed by physicians familiar with the methods of diagnosis and treatment of intraepithelial carcinoma of the cervix should greatly reduce the occurrence of invasion cervical carcinoma.

DIAGNOSIS

A strong suspiciousness of the possible existence of the intraepithelial carcinoma of the cervix in any female patient and a carefully performed pelvic examination are the most important factors in diagnosis.

1. *Age.* The average age at the time the diagnosis of intraepithelial carcinoma was made in our cases was 42, with an age spread of 19-69. The importance of examining younger women is exemplified by the fact that 10 of our patients were 30 years of age or less. It also means that we may not be screening enough of the younger women, for the average age of our patients was 7 years older than that reported by others.

2. *Symptoms.* One-third of our patients had no pelvic symptoms referrable to the cervix. The others complained of intermittent vaginal spotting or bleeding, postcoital spotting and leucorrhea.

3. *Signs.* The cervix appeared grossly normal in over one-third of the cases. In the others, the cervix revealed erosion, cervicitis and leucoplakia. In a number, biopsies and smears were taken because benign-appearing cervical lesions bled on sponging during the examination.

4. *Papanicolaou Cytologic Smears.* The cells of the intraepithelial carcinoma of the cervix are constantly being exfoliated and can be made readily available for study in properly prepared slides of scrapings of the posterior vaginal fornix, the squamo-columnar junction of the cervix and the endocervix. The

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procedure is painless, takes only a minute to perform and there are no contradictions.

Correctly taken smears will reveal the existence of unsuspected intraepithelial carcinoma of the cervix more frequently than any other technic. Ideally, they should be taken on all female patients on their first office visit when a pelvic examination is indicated and on all obstetric patients at the time of the first antepartum visit. *Smears should be a routine procedure prior to any local therapy to the cervix at any age.* Once taken, we recommend repeat smears each year. These smears are of little value in the identification of the existence of adenocarcinoma of the endometrium and smear technic should not be relied upon to rule in or out this condition.

Technic. The smears must be taken before the bimanual examination as the lubricant used and the trauma of the examination will destroy the value of the smears. A dry speculum is inserted into the vagina, exposing the cervix. The longer projection of the notched end of the Ayre's wooden spatula is inserted into or against the cervical os and a circular scraping is made of the squamocolumnar junction. The material obtained is spread thinly on a clean slide. Using the other end of the spatula, gentle scraping is made across the post vaginal fornix and the material spread on a slide. A small cotton swab is then inserted gently into the endocervical canal for a distance of about ½ inch, the stick twisted around several times and the material spread on a slide. Each slide, as soon as prepared, is immediately immersed in a solution of one-half ether and one-half 95% alcohol.

Interpretation of the Cytologic Smears. To be reliable in identifying or ruling out an intraepithelial carcinoma, the slides must be interpreted by a trained technician and a pathologist experienced with this technic. There are a sufficient number of experienced pathologists, geographically located in various parts of Indiana, to make this cytologic diagnostic technic available to every physician in the state.

Report—Smears "Negative". If correctly taken, this report for all practical purposes rules out the existence of an intraepithelial carcinoma. Smears should be repeated annually. Physicians should not become discouraged if smear reports are negative for a large number of patients. It must be remembered that positive reports will probably be made on less than 1% of the patients, for the cytologic smear technic is largely a screening method. However, for that patient in whom an unsuspected potentially lethal lesion is discovered in a curable stage, the routine smear becomes eminently worthwhile. We have found the other patients with negative smears greatly appreciative of the assurance given them by the fact that, by modern methods, the possible existence of cancer of the cervix has been ruled out.

a). If the smears are negative, but there is a gross lesion of the cervix, cervical biopsies should be carried out.

Report—Smears "Suspicious". These smears should be repeated and if negative on the next report, follow-up smears are advised at six-month intervals. If, however, repeat smears are reported as suspicious, a biopsy should be performed if there is a gross lesion or a conization and curettage if no gross lesion is present.

Report—Smears "Positive for Cancer Cells". Treatment is never undertaken based only upon positive smears for several reasons. First, the actual cervical lesion may be an invasive cancer, and the treatment recommended for intraepithelial carcinoma is inadequate for invasive malignancy. Second, inflammatory reactions of the cervix may produce exfoliated cells which closely resemble the cells of malignant lesions. Positive smears constitute indications for quadrant cervical biopsies and biopsy of any cervical lesions. If no gross lesions are present, a surgical conization and curettage is indicated.

5. *Cervical Biopsies.* The pathologist can make a diagnosis only on the tissue submitted to him. Therefore, it is the responsibility of the physician taking the biopsies to obtain adequate material for study. We have found that four quadrant biopsies at 12, 3, 6 and 9 o'clock positions about the cervix at the squamo-columnar junction provide adequate

sampling of the cervical lesion to ensure accuracy of diagnosis. It is advisable to use a sharp Gaylor punch biopsy instrument, taking the biopsies first at the 6 position and then at the 9, 3 and 12 positions. This will prevent the bleeding which may occur from the anterior lip biopsy from obscuring the other biopsy sites. A simple vaginal tampon or gauze dressing packed tightly against the cervix usually suffices to control the bleeding. We prefer not to cauterize the lesion until the pathological report of the biopsy is available, as the pathologist may request more tissue and cautery destroys the opportunity to obtain more material for satisfactory tissue study. *Biopsies should be made of all cervical lesions which require cautery, especially if the lesion bleeds on sponging, and all lesions which fail to heal after cautery.*

Interpretation of Pathological Report of Biopsies.

1. Biopsies negative for intraepithelial or invasive malignancy.
 a) Cytologic smears also negative. Repeat cytologic smears at yearly intervals.
 b) Cytologic smears suspicious. Repeat smears at 6-month intervals.
 c) Cytologic smears positive. Surgical conization and curettage to have the opportunity of studying pathologically the other areas of the cervix.
2. Biopsies positive for intraepithelial carcinoma. We recommend surgical conization and curettage for several reasons.
 a) Invasive carcinoma may exist in other areas of the cervix.
 b) The biopsies may have removed all evidence of the intraepithelial carcinoma.
 c) The intraepithelial lesion may be widespread over the surface of cervix.

Three recent cases exemplify the importance of following the biopsy with a surgical conization before undertaking definitive therapy. Each of the three patients had positive cytologic smear reports, each had a benign-appearing cervical erosion and each had a biopsy report of intraepithelial carcinoma. Study of the tissue obtained by surgical conization revealed the following: one patient had an early invasive malignancy, another had an extensive intraepithelial carcinoma of the cervix, and the third showed no evidence of intraepithelial or invasive malignancy.

6. *Surgical Conization of the Cervix.* This should be a hospital procedure carried out under general anesthesia. The intraepithelial lesion is easily separated from the underlying tissue and thus a definite routine should be followed to insure that the cervical tissue be removed with the epithelium intact. If the gross cervical lesion is small or there is no gross cervical lesion, a small circular wedge-shaped area of tissue, including the entire squamocolumnar junction, is removed with a knife blade. If the cervix is bilaterally lacerated and the lesion is large, it is advisable to remove sizable rectangular wedge-shaped pieces of tissue from the four quadrants about the cervix with the knife before proceeding with the dilatation and curettage and the usual conization with the cutting current. Tissue so removed provides the pathologist with adequate material upon which to make a definite diagnosis. When this report is available, we are then in a position to decide upon definitive treatment.
7. *Diagnosis in Cases in our Series.* In the 32 cases, suspicion of the existence of intraepithelial carcinoma of the cervix was aroused by obtaining positive cytologic smears in 16 cases. Primary cervical biopsies or cervical conization showed intraepithelial carcinoma in 10 cases. In 6 cases, an unsuspected intraepithelial carcinoma was discovered in the pathological examination of the cervix after total hysterectomy.

The final diagnosis of intraepithelial carcinoma of the cervix was established in our cases by surgical conization in 21 cases, by biopsies only in 5 cases, and in 6 cases by incidental finding after total hysterectomy for other causes. The biopsy cases occurred early in our study and, in view of our further experience, we would recommend surgical conization in these cases before decision as to definitive treatment.

TREATMENT

1) Smear positive, biopsy positive, conization negative for intraepithelial or invasive malignancy. The biopsies apparently removed the entire intraepithelial lesion and no further treatment is indicated. These patients should be followed with cytologic smears each 6 months.

2) Smear positive, biopsy positive, conization reveals intraepithelial carcinoma of the cervix.

 a) We advise simple total hysterectomy, including the removal of a ¾ inch vaginal cuff, as the intra-epithelial changes at times may spread beyond the confines of the cervix. The ovaries may be removed or not removed, depending on the age of the patient.

 b) We feel justified in making an exception to the above recommendation in the special instances in which the patient is young and childbearing is an important issue. If the tissue removed by conization shows a wide zone of normal epithelium beyond the intraepithelial involvement, the patient may be followed without further definitive treatment if two conditions are fulfilled. First, that the patient and her husband understand the slight risk involved, and second, that the patient will cooperate in having repeat cytologic smears every 4 months.

 c) Some have recommended that radium and external irradiation be administered to these patients. We feel that by insisting on pathologic examination of the tissue removed by conization before the diagnosis of intraepithelial carcinoma can be established, the possibility of treating an undiagnosed invasive malignancy by simple total hysterectomy will be eliminated. We would recommend radium if because of the medical condition of the patient hysterectomy was definitely contraindicated.

Treatment of 32 Cases. Total hysterectomy was performed in 21 cases. In 6 cases, the diagnosis of intraepithelial carcinoma of the cervix had not been made before surgery. In the remaining 15 cases, residual intraepithelial carcinoma, well within the confines of the surgically removed material, was found in 5 cases.

In 7 patients, conization was not followed by any further treatment. Three of these patients have subsequently become pregnant and delivered term infants. In none of these 7 patients has there been any evidence of recurrence of the intraepithelial lesion.

Three patients were treated with radium and have remained free of recurrence.

In one patient, repeated biopsies failed to reveal any further evidence of intraepithelial carcinoma although the original biopsy presented a very definite intraepithelial lesion. This patient is being followed by periodic cytologic smears.

RESULTS

All but one of the patients have remained free of recurrence of the intraepithelial carcinoma of the cervix to date (1-5 years). These patients will have to be followed over a period of many more years before a final statement can be made regarding their eventual outcome. In one case, there has been a recurrence in the vaginal vault. The diagnosis in this patient was equivocal in that even after repeated biopsies and conization, pathological examinations of the tissue did not reveal conclusive evidence as to whether the lesion was exclusively an intraepithelial one or whether there was borderline evidence of invasion. A radical hysterectomy and removal of a wide vaginal cuff was performed. The pathological interpretation of this tissue was also equivocal. Two years later, a recurrence of an intraepithelial lesion appeared in the vaginal vault. Intravaginal radium was applied and the patient has remained free of further recurrence 3 years later.

PREGNANCY AND INTRAEPITHELIAL CARCINOMA OF THE CERVIX

This aspect of the problem deserves separate consideration because the epithelium of the cervix of pregnancy can undergo changes which closely resemble the pathologic picture of intraepithelial carcinoma only to regress postpartum returning to a normal-appearing epithelium. In our series, there were 4 such cases proven by

biopsy and surgical resections of cervical lesions during pregnancy. Each of these patients was followed postpartum by cytologic smears, and tissue removed by multiple biopsies showed only chronic cervicitis with no evidence of intraepithelial change.

In two other cases during pregnancy, however, the epithelium obtained by the biopsies and surgical resections of the cervix revealed changes which were very definitely those of intraepithelial carcinoma. This diagnosis has been confirmed by a number of different pathologists who have reviewed the slides. Each patient was permitted to continue her pregnancy to term and deliver vaginally. Postpartum smears and biopsies were repeatedly negative. Each patient has had a subsequent pregnancy and no evidence of recurrence of the intraepithelial carcinoma has appeared 3 years after the original diagnosis was made.

A recent case emphasized the importance of obtaining more tissue for pathologic study after the original biopsy revealed intraepithelial carcinoma of the cervix during pregnancy. Surgical resections of the cervical lesion showed evidence of an invasive malignancy. This patient, being in the first trimester, was treated by hysterotomy and then external irradiation and radium.

In pregnancy, therefore, adequate tissue must be obtained for pathologic study for the following reasons:

1) To make certain the diagnosis is one of intraepithelial carcinoma and not a marked degree of basal cell hyperplasia.

2) To make certain that invasive carcinoma is not actually present.

Once the certainty of intraepithelial carcinoma is established during pregnancy, one may safely wait until the postpartum period to obtain further tissue for study and decision regarding definitive therapy.

THE DATE WAS 1914

When, in the course of cancer therapy, the physician understandably becomes discouraged and momentarily feels that further progress is wishful thinking, he might well find reassurance in this excerpt from *International Clinics* on the progress of medicine.

"The x-ray has been developed to the highest point of intensity and perfection and that must suffice. The time is not too far distant when the world will know about it."

The date was 1914.

—The Cancer Bulletin

Cancer of the Prostate: A Plea for Early Diagnosis

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PROSTATIC CARCINOMA is the commonest neoplasm of men over the age of 50. It occurs in 17.7 per 100,000 population and constitutes 12.2% of all malignancies in males. The occurrence in autopsy series varies from 14% to 26% and is present in 25% of all who have symptoms of prostatic obstruction.

It is doubtful that the above statistics are appreciated by all practicing physicians. We hope that after reading the following discussion it will be evident to the reader that major emphasis is placed on early diagnosis so that a cure can be offered to these patients. This means free use of the examining finger in the rectum.

It is now generally believed that the stimulus which causes the prostatic acinar cells to assume the characteristics of a neoplasm result from an imbalance of the ratio and quantity of circulating male and female hormones. While it is generally felt that the androgenic or male hormone is the prime stimulus, why this tumor develops during the decline of sexual activity when the androgens are dropping is not understood. Fortunately the neoplasm arises in the posterior lobe where it can easily be palpated. It spreads locally throughout the prostate, then through the prostatic capsule by the perineural lymphatics and into the periprostatic tissue about the seminal vesicles and into the prostatic ligaments. Distant spread is to the bones of the pelvis and spine, producing radiographically characteristic osteoblastic lesions.

The diagnosis of early prostatic carcinoma is ultimately made by the pathologist and the microscope, however the suspected diagnosis is made by the simple maneuver of rectal palpation of the prostatic gland. It is unfortunate that early lesions are uniformly asymptomatic, but this is counterbalanced by the accessibility of this early lesion to the finger of the examining physician. Perry Hudson, in his now famous Bowery series, found rectal palpation to be accurate in over 80% of proven cases of carcinoma. The early lesion is usually a small localized area of induration felt at the apex or in one of the lateral lobes. The hard fixed nodular textbook picture of prostatic carcinoma is not that of the early localized lesion. Once a lesion is suspected and removal deemed feasible, the area should be exposed, preferably by the perineal route, a section of the tumor removed and studied by frozen or permanent section. Perineal needle or aspiration biopsy and transrectal biopsy is generally not recommended when the lesion is small and surgical removal is contemplated. In large inoperable glands this maneuver will often give final proof of the rather obvious condition, and aid in choosing the appropriate treatment. Other diagnostic aids which should be mentioned but which have not been proven reliable or practical yet are the cytological study of the prostatic fluid and chemical survey tests of urine and blood.

The diagnosis of late carcinoma where a surgical cure is impossible is again suspected on rectal examination. The gland is very frequently stony hard, nodular, and often fixed to the pelvic wall. The tumor growth can be felt outside the capsule about the seminal vesicles and vasa deferentia. Frequently symptoms of prostatic obstruction are present and upon cystoscopic examination there may be evidence of

extension into the bladder neck and trigone. X-rays of the bony pelvis often reveal osteoblastic metastasis and if the trigone is invaded there may be stasis as shown on intravenous urograms.

In metastatic prostatic carcinoma the acid and alkaline phosphatase levels may be helpful. Nesbit and Baum in their series of 1,150 cases found a significant elevation of the serum acid phosphatase levels in patients with metastatic spread. They concluded that an elevated serum acid phosphatase was pathognomonic of metastatic prostatic carcinoma, but that a normal value does not rule out disseminated or localized neoplasm. Recent work on the levels of the prostatic fraction of the serum acid phosphatase has produced a more critical and exacting test, but apparently still does not aid in the diagnosis of localized lesion.

TREATMENT AND PROGNOSIS

For purpose of clarity, it is best to discuss treament under two separate categories: (1) operable and (2) inoperable.

Operable

What do we mean when we say operable? Simply defined, it means that the neoplasm must be wholly confined to the prostate gland. Local extraprostatic involvement as well as distant metastases precludes cure by radical surgery. Early cancer of the prostate is seldom if ever symptomatic. It is usually found by an alert examiner during a routine physical examination which includes digital rectal palpation. The finding of a suspicious nodule on the prostate which is firmer in consistency than the remainder of the gland should be evaluated by consultation. Physicians in the general practice of medicine and those doing internal medicine are the ones who will pick up these early cancers for which a cure can be offered. This statement cannot be too strongly emphasized. The importance of this is realized when it is known that according to the statistics of various centers throughout the United States, the urologist encounters only about 5% that are clinically considered operable. The remaining 95% are seen too late to render treatment other than palliative. Given then a patient with a nodule on his prostate which is confined within the capsule, without evidence of distant metastasis, a normal serum acid phosphatase and his general physical condition permitting, the course of treatment is clear. Biopsy of the nodule should be done and if positive, radical prostatectomy performed.

It is now necessary to introduce a few statistics relative to surgical cure rates and mortality. This will help the reader understand why we so strongly advocate radical prostatectomy when indicated.

Jewett analyzed 190 cases of proven cancer of the prostate which were removed by the radical perineal route at Johns Hopkins Hospital from 1904-1948. Detailed case records showed that in that group, 78 patients were judged by rectal examination to have the cancer confined to the prostate gland. Forty are living or have lived five years or more without evidence of cancer, a survival of over 50%. Thirty-seven per cent survived 10 years without evidence of cancer. Expected 10 years survivorship of this group by life insurance companies is 53%.

Similar survival rates approximating 50% have been reported by many others including Belt, Colston, and Hinman.

Smith reported 76 consecutive cases subjected to radical perineal prostatectomy during the past 20 years. Thirty-three per cent lived more than five years and 15% lived more than 10 years.

Operative mortality must be considered. In Jewett's total group of 190 cases, there was a mortality of 6.3%. In the last 10 years this dropped to 4.7% of 127 cases. In the last 100 cases the mortality was only 3%, and in the last 50 cases there were no deaths. In Smith's series, there were two deaths in 76 cases or an operative mortality of 3.7%.

A recent survey was made of 1,125 urologists, members of three representative sections of the American Urological Association concerning management of early cancer of the prostate. About 50% responded. It was of interest to learn that about 50% favored the perineal approach and 30% the retropubic. The type approach matters little, but the gain in popularity of the retropubic should encourage the urologists untrained in perineal surgery to become more aggressive in the treatment of this disease. We personally prefer the perineal route because of the easy accessibility to the nodule in the prostate for frozen section biopsy as well as lower morbidity. Should the reader be interested in surgi-

cal technique, he is referred to the original work of Millin, Young and Davis.

Inoperable Prostatic Cancer

It is unfortunate that 90-95% of cancer of the prostate that is first seen in the urologist's office falls into this group. Treatment of these patients may be classified under three major headings: (1) Relief of urinary obstruction; (2) Slowing of the cancer growth; (3) Control of pain.

The major number of patients that we see for the first time with cancer of the prostate come to the office due to some symptom suggestive of bladder neck obstruction. There is pretty much a uniformity of opinion that if the obstruction is severe enough to cause residual urine, transurethal resection of the obstructing tissue is indicated. This procedure as a rule will remove the necessity of a permanent catheter life except possibly in the far advanced late stages. This is an individual problem and must be evaluated accordingly with each patient. Some patients are observed late enough in the progress of their disease that even transurethral resection will be of little benefit. In these, simple trocar cystostomy for permanent suprapubic drainage is done. This is more comfortable than permanent urethral drainage and will, of course, prevent the complications of urethritis, periurethral abscess, fistula, and epididymitis which so often accompany a catheter in the urethra.

Management of disseminated prostatic cancer was conceived by Huggins and published in 1941. He states: "All known types of adult prostatic epithelium undergo atrophy when androgenic hormones are greatly reduced in amount or inactivated. Therefore, significant improvements should occur in the clinical condition of patients with far advanced prostatic cancer subjected to castration (and/or estrogen administration.)" Space, of course, does not permit a complete discussion of this important work, but it should be understood that present day estrogenic management of these patients is based upon this extensive research.

Since this original work, physicians have treated thousands of patients afflicted with cancer of the prostate either by estrogens, castration, or both. Many reports have become available during the last 14 years and probably one of the most significant is that of Nesbit and Baum, published in 1950.

Briefly, their work presented a statistical survey of 1,818 cases of cancer of the prostate subjected to endocrine therapy. Bilateral orchiectomy plus diethylstilbestrol, 5 mgm/24 hrs. or less, which was continued throughout life, resulted in the greatest percentage of five year survivals. Forty-four per cent survived. There was no evidence of metastasis in this group on first admission. A control series of 783 patients before endocrine therapy gave only 10% five years survival. When diethylstilbestrol alone was used there was a 29% survival, and with castration alone, 31% five years survival, each alone thus less effective than the combination.

If metastasis was found on first admission, 20% lived five years with combined castration and estrogen or castration alone. Estrogens alone showed only 10% living after five years.

Ganem recently (Dec., 1955) reviewed clinical records of 221 patients with advanced cancer of the prostate seen on the urological service of Massachusetts General Hospital. He found 59% had a chance to live five years if treated by castration and stilbestrol and transurethral resection when indicated, providing the upper urinary tract was normal, a normal serum acid phosphatase, and no demonstrable bone metastasis. If hydronephrosis is evident or elevated serum acid phosphatase without bone metastasis is found and treated in the same manner, his five years survival drops to 31% or 32%. If, in addition to hydronephrosis, an elevated serum acid phosphatase and bone metastasis are found, his five years survival approaches 0%.

It is rather apparent from the previous discussion that the early treatment of prostatic cancer is surgical removal of the gland and that castration plus estrogens be offered to those patients that would be grouped inoperable.

Adrenalectomy for inoperable prostatic cancer was revived in 1951 by Huggins and Bergenstal. West, Hollander, Whitmore, Randall and Pearson of the Memorial Hospital in New York City listed their work in 1952 (10 cases.) Baker reported 10 in 1953. Consensus seems to be fewer and fewer bilateral adrenalectomies for prostatic cancer and more and more for cancer of the female breast. Pain is often relieved but survival time is no longer and the patient's life is dependent upon rigid control of cortisone admin-

istration. We have had no personal experience in this field and feel that unless present day concepts change there will be no stimulus to pursue it further.

The use of cortisone is often beneficial to these patients. Sprague, in 1950, brought out in discussing the physiological effects of cortisone that it caused a depression of the endogenous production of adrenal cortical hormone and urinary 17-ketosteroids. As a result of this work, Miller and Hinman, Jr., in 1954, reasoned that the use of relatively large doses of cortisone in patients with advanced prostatic carcinoma might produce a "medical adrenalectomy" that could be as effective as actual surgical bilateral adrenalectomy. Their results of 10 cases so treated are comparable to those reported after bilateral adrenalectomy. With either treatment, the effects are temporary.

Radioactive isotopes are being investigated for the locally extensive prostatic cancer. In 1953, Flocks reported early experience in the use of radioactive gold, Au. 198, in 69 patients. It is too early in this experimental work to draw conclusions. Cure of the cancer will probably never be obtained with this method.

Perfusion fluid technique of the prostate gland with androgens and estrogens, observing the alterations of the gland are being done by Scott, who is also studying the effects of hypophysectomy in humans with far advanced prostatic cancer.

Control of pain is the chief concern of the patient in the advanced stages. Help is frequently sought from the neurosurgeon for what relief he may be able to offer the victim. X-ray therapy sometimes helps. Eventually the patient becomes bedridden and it is necessary to rely upon narcotics. When this period is reached we are in full sympathy with the unfortunate patient and strongly advise free use of whatever drugs are needed to keep him comfortable. How insignificant addiction is at this time!

CONCLUSIONS

Treatment of cancer of the prostate has been divided into main groups: (1) operable and (2) inoperable.

Because of the excellent results that can be obtained in the operable group, (50% five years survival) we are urgently requesting that suspicious lumps or nodules in the prostate as felt with the examining finger not be disregarded. Consultation is desirable. All men over 45 years of age should certainly have a rectal examination done once a year and the examining physician should carefully evaluate the contour and consistency of the prostate gland. Deliberate search for small nodules within the gland must be a part of the routine examination, for these are the ones that can be cured. Urologists should be alert and trained to perform a radical prostatectomy if indicated.

The management of advanced cancer of the prostate is essentially palliative. Transurethral resection is necessary usually for obstructive symptoms and findings. Castration and estrogens statistically show better results when combined than singly. Cure of the cancer will never be obtained in this group.

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The Use of Cytology in Cancer

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THE CYTOLOGIC METHOD is now commonly used as an aid in cancer diagnosis. Although this method was first described about a century ago,[1] it was relatively neglected until the past 10 years.[2] Previously cytologic studies were done chiefly to detect cancer cells in sediment from pleural and peritoneal fluids,[3, 4] generally by the cell block technic.[5, 6] At present materials from many sites in the body are examined for the presence of exfoliated cancer cells.[7, 8]

In order for cancer cells to be detected in exfoliates or scrapings the tumor must extend to a body surface. The tumor may be present in the wall of a hollow tube such as a bronchus or the stomach, or on body surfaces such as the uterine cervix or the pleura. If cells are not readily obtainable by natural exfoliation, they may be removed by mechanical abrasion. The material obtained may be examined by preparing smears or making cell blocks of sediment and sectioning in paraffin in the manner followed for tissue specimens. The staining method employed varies from laboratory to laboratory, depending upon the whims and experiences of the pathologist. There is nothing diagnostic in the staining reaction; the pathologist relies upon morphologic changes resident within the cells. In the diagnosis of tissue sections the pathologist is guided not only by the structure of cells, but also by the relationship of cells to one another and to adjacent tissues. Although there are shortcomings in the cytologic method in the diagnosis of cancer, it is a helpful adjunct. Because of the serious consequences following the diagnosis of a malignancy, whenever possible positive diagnoses by the cytologic method should be substantiated by histological examinations.

INDICATIONS FOR CYTOLOGY IN CANCER

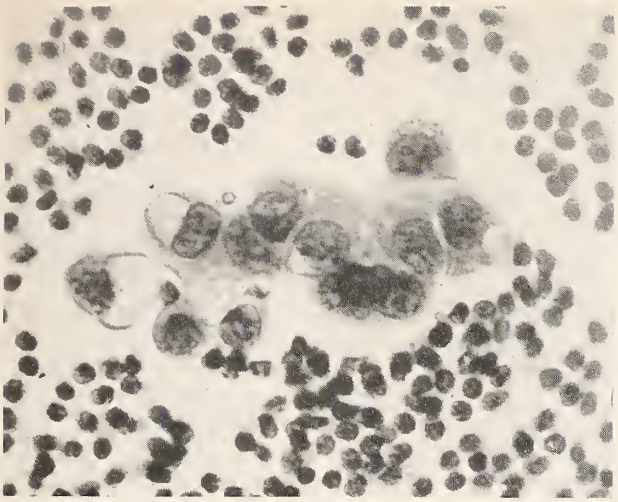
1. Detection of unsuspected cancer. Cytology is employed most extensively in detecting malignancies of the female genital tract, especially of the uterine cervix. Routine cytologic examinations of vaginal and cervical specimens for women over 30 years of age, especially those with gynecologic complaints, is advocated. In some studies an average of one unsuspected cancer has been detected in each 300 cytologic examinations. Routine use of cytologic methods for detection of cancer in other sites has not proved practical.

2. Detection of suspected but relatively inaccessible cancer. The examination of sputum and bronchial washings is the prime example of this indication for cytologic examinations.[9] Most operable carcinomas of the lung are not accessible for biopsy by bronchoscopy, and the finding of exfoliated cancer cells is important in establishing the diagnosis preoperatively.

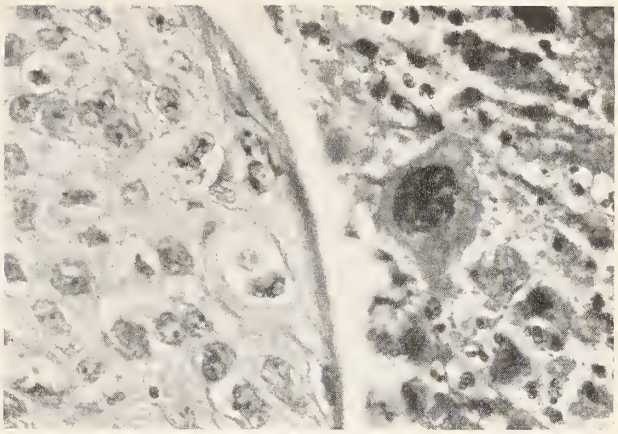
3. Detection of metastases from known or suspected tumors to distant sites. The examination of pleural and peritoneal fluids is done chiefly to determine whether metastases exist on the serous membranes.[10, 11]

4. Detection of therapeutic effect in known cancer. The effect of radiation therapy in carcinoma of the cervix may be followed by examination of vaginal secretions for the disappearance or persistence of cancer cells. It has also been suggested that the effects of radiation therapy on non-malignant epithelial cells in the vaginal tract may be an indication of the effectiveness of radiation therapy.[12] The effect of radiation therapy (external radiation or intra-

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1. A cluster of carcinoma cells in a smear of sediment from pleural fluid (high power magnification).



2. Exfoliated carcinoma cells (right of figure) in exudate in a bronchus overlying an area of epidermoid carcinoma (moderate magnification). Similar exfoliated cells were present in the sputum of the patient.

cavitary radioactive isotopes) on cancer involving the pleura or peritoneum may be gauged by subsequent cytologic examination of the aspirated fluid.

METHODS OF REPORTING CYTOLOGIC FINDINGS

The pathologist may report the findings of his examination in various ways. One of the most frequently employed methods of recording the results is the classification system of Papanicolaou.[13]

Class I: Absence of atypical or abnormal cells.

Class II: Atypical cells but no evidence of malignancy.

Class III: Cells suggestive of but not conclusive for malignancy.

Class IV: Cells strongly suggestive of malignancy.

Class V: Cells conclusive for malignancy.

Thus, Class I and Class II are negative, Class IV and Class V are positive, and Class III is doubtful.

In our laboratory we prefer to report our findings in the manner suggested by Ackerman.[14] This classification system does not use numbers because the pathologist's interpretations are not as exact as numbers indicate. The statements usually used are:

No cancer cells are seen.

There are atypical cells, the exact nature of which we are not certain.

We believe cancer cells are present.

Specimen is unsatisfactory (stating reason).

All doubtful examinations should be repeated until the nature of the atypical cells is ascertained. If possible, instances in which cancer cells are believed to be present should be substantiated by biopsy.

COLLECTION OF SPECIMENS

1. Cervical and Vaginal Material. The exfoliated cells from the female genital tract collect in the vaginal fornices. For this reason the secretions in the posterior fornix are well worth examining for tumor cells. This material may be collected by means of a pipette and bulb[15] or by the use of a wooden spatula. Several drops of the material are placed on a glass slide, and a *thin* smear is made. If it is difficult to spread the material, a second glass slide may be placed on the first and a pull-film made by drawing one slide across the other. The slides are placed in a fixative when the edges of the smears begin to dry. A similar set of smears should be obtained by scraping the cervix at the squamo-columnar junction or by aspirating material from the endocervical canal. Fixatives which are commonly used include 95% methyl or ethyl alcohol, acetone, 10% formalin, or a mixture of equal volumes of ether and 95% alcohol. The patient should not douche prior to the preparation of vaginal and cervical smears because accumulated secretions are lost. Lubricating materials should not be used prior to the collection of the specimen.

2. Sputum. In order to obtain satisfactory

results the specimen must be collected properly. We feel that at least six separate specimens should be submitted before the study of the sputum is terminated. The patient should be instructed to cough deeply in order to obtain material from the bronchi. Saliva and nasal secretions should not be included in the specimen. We prefer to examine only sputum brought up during the night and before breakfast. The specimen should be sent to the laboratory in the fresh state if possible. If fixation is required because of a delay in handling the material, it may be preserved in 70% alcohol or in 10% formalin.

3. Pleural, pericardial, and peritoneal fluid. The specimen should be collected in a clean container and sent to the laboratory immediately. If delays in handling the specimen are encountered, about 50 cc. of the fluid may be placed in an equal volume of 95% alcohol or in 10% formalin for preservation until it is examined.

4. Gastric secretions. The pathologist should be consulted before this procedure is done. To eliminate food contamination of the specimen, overnight fast for the patient without obstruction is recommended. Water is permitted and should be urged to avoid dehydration. If obstruction is present, the patient should have a liquid diet for several days prior to the examination, and thorough gastric lavage the evening before examination is to be done. Roentgenograms of the upper gastrointestinal tract should not be done for several days prior to cytologic study since barium contamination of the cellular sediment makes the slides difficult to interpret. The tube for aspirating the specimen is passed through the mouth to avoid contamination with cells of the upper respiratory tract. The gastric material should be obtained in the manner preferred by the pathologist:[16, 17] gastric brush, abrasive balloon, or washings with saline. We prefer the latter method. This material must be centrifuged and smears made and fixed immediately because the cells are destroyed very rapidly.

5. Other material. Spinal fluid,[18] urine,[19] nasal antral washings, esophageal washings, nipple discharges, endometrial aspirates, and other material may also be examined. Before these materials are collected, the pathologist should be consulted about his methods of handling the specimens. Cells in urine and spinal fluid are rapidly destroyed, and smears must be prepared as soon as practical, certainly within the first 30 minutes after collection.

DATA NECESSARY FOR INTERPRETATION OF SMEARS

There are certain changes occurring in nonneoplastic exfoliated cells which may be confusing if no history is available to the cytologist. For this reason the specimen should be accompanied by certain data including the patient's name, age, sex, and site of origin of the collected material. For cervical and vaginal smears, data concerning the dates of the patient's last menstrual period, menstrual irregularities, hormone therapy, pregnancy, presence of trichomonas infestation, previous radiation therapy, or recent operative procedures should be supplied. For all specimens the clinical diagnosis and other pertinent clinical data are essential in order to avoid errors.

SIGNIFICANCE OF RESULTS

Negative results in cytologic examinations do not exclude the possibility of the presence of cancer, especially if only one examination is done. If the specimens are collected properly and the smears prepared and examined carefully, more positive diagnoses can be obtained. Whenever possible these should be substantiated by histologic methods.

SUMMARY

The examination of smears for the presence of exfoliated or abraded cancer cells from body surfaces is a useful adjunct in detecting unsuspected malignancies or suspected but relatively inaccessible malignancies. The cytologic method is also valuable in detecting spread of known cancers and detection of therapeutic effect of radiation therapy in some sites.

The collection of materials for cytologic examinations is not difficult, and all physicians should become familiar with the details of collection. The material must be prepared for study immediately or else preserved so that alterations in cells do not occur after collection of the specimen.

Negative results are of value but do not

exclude the presence of cancer. Whenever possible, positive results should be confirmed by biopsy.

Acknowledgment: The photographs were prepared by Mr. James F. Glore and Mr. Paris Johnson of the Department of Illustration.

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"LEAVE NO STONE UNTURNED"

To the untrained observer, the academic or basic research approach to the relief and cure of cancer often appears slow and remote. Actually, the step-by-step elucidation of basic facts is necessary before the more dramatic applied research can be made. No approach, however remote, is unimportant. For this reason, all problems which might possibly lead to the ultimate answer are being investigated.

—The Cancer Bulletin

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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ED LAWRENCE MEMORIAL ISSUE

EACH YEAR the April issue of THE JOURNAL is devoted to the subject of malignancy. The editorial staff is proud to dedicate the 1956 issue to the memory of Dr. Edwin A. Lawrence, who aided in planning this issue, and who died during its preparation, on February 20, 1956.

Dr. Lawrence was professor of surgery and cancer research coordinator for Indiana University School of Medicine. He was widely known throughout the state for his work with the many lay organizations interested in cancer research. For several years he organized and conducted the Annual Symposium on Malignancy, a postgraduate course for practicing physicians.

Dr. Lawrence was a graduate of Oberlin College and received his medical education at Western Reserve University School of Medicine. Before coming to Indiana in 1950 he was a member of the surgical faculty of Yale University School of Medicine and later of the University of Utah School of Medicine.

His contributions to the surgical literature were many and varied, and he was a member of many learned scientific societies.

He was a very active member of the Indiana State Medical Association, served on many of its committees and each year served as an (until now) anonymous adviser and valued consultant in the publication of our annual issue on malignancy.

By dedicating this issue of THE JOURNAL to him, the staff of THE JOURNAL and the Indiana State Medical Association wishes to acknowledge Ed Lawrence's contributions to medical education and cancer research, and to record his accomplishments for the State Association and its Journal.

MEDICAL EDUCATION WEEK

NATIONAL MEDICAL EDUCATION Week will be celebrated for the first time during the week of April 22 to 28. County medical societies, state medical associations, and the A. M. A. plan to cooperate with newspapers, radio, television and with community organizations to highlight the American Medical Education Foundation and its drive for funds to support the medical schools of the nation.

While the American Medical Education Foundation receives contributions from physicians and medical organizations, the National Fund for Medical Education serves as its counterpart for industrial and non-medical contributors. Both have functioned on a high level for several years and are now expanding their publicity with a view to attracting donors on an enlarged scale.

Medical school budgets have been aided to the extent of several million dollars on a national basis ever since the funds were organized. There is not only a need to continue this support but also every good reason to improve upon it. Medical education is still expensive, endowments and other items of income are still insufficient, and the ten million per year that was originally estimated as the total need has never been procured for any one year.

The dollars that doctors give serve double duty. They swell the total fund and aid in the obvious way. They also serve as a stimulus for the benevolent impulses of industrialists and other non-medical citizens. Many of the large contributions in the past have come from business and industry. An increasing number of donations and an increase in size of donations may be expected if the doctors themselves demonstrate a wholehearted and continuing support of the fund.

Everybody benefits from good medical education. Everyone is interested in good medical education. Industry and business realize this and are willing to aid in the maintenance of medical schools free from federal domination. The entire problem, however, is close to the medical profession, and nobody will be apt to be more interested in it than the doctors themselves. It is for us to lead the way. If we show our interest there will be a lot of others on the bandwagon. If we don't, there won't be any other interest.

Our own state association committee will be encouraging the giving of funds. Every doctor owes something on his medical education. Now is the time to repay part of that obligation. The practical side of it is that the donation is federal income tax deductible, and also the check writing is a little easier if you remember that each doctor's dollar attracts several other outside dollars to a good cause.

SALUTE TO A 150TH ANNIVERSARY

THE MEDICAL SOCIETY of the County of New York is celebrating the 150th anniversary of its founding. The society was formed in 1806 by 102 physicians who met on the steps of New York City Hall and publicly proclaimed the existence of their organization for the advancement of medicine.

One of the events of the sesquicentennial celebration which is taking place this month is a reenactment of the founding ceremony. Historical exhibits, special hospital programs, open house and exhibits in the five New York medical schools, television and radio programs and a special cancellation postmark will all help to mark the occasion.

New York County consists of the Island of Manhattan. Its medical society is the largest in the nation with 7,000 members. During the celebration they will review the scientific ad-


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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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vances of medicine, and also consider their achievements in solving the newer problems of medical care—medical economics, public relations, health information, medical care plans, and public service projects.

The entire medical profession can take pride in this 150 year record of progress. It is a pleasure to salute the Medical Society of the County of New York, and wish them many more happy birthdays.

Letters to Editor:

Journal of the Indiana State
Medical Association
1017 Hume-Mansur Building
Indianapolis 4, Indiana

Dear Sirs:

An error was present in the article, Human Infection with Leptospirosis Pomona in Indiana, published in the October 1955 issue. The results reported were obtained with the complement fixation test and not the agglutination test. The complement fixation test is diagnostic above the 1:8 dilution.

If it is possible, I believe it would be of value to publish a correction of this error in The Journal. Thank you for your kind attention in this matter.

Yours truly,

JOHN H. IVY, M.D., Elkhart.

BELGIAN GOVERNMENT SURRENDERS TO WISHES OF THE MEDICAL PROFESSION

The Belgian government has unconditionally surrendered to the demands of the medical profession to withdraw its attempt to regulate medical care and medical service under its Social Security scheme through legislative status. In addition it has agreed to accept the principle of non-intervention through law and to recognize the conventions agreed upon through the joint efforts of representatives of the medical profession and the insurance companies.

In September 1955 the Belgian government instigated legislative measures which would regulate all activities in medical service and medical care. The Belgian doctors, united in their desire to remain a free profession and to protect the rights of the people receiving medical care under the Social Security plan to receive the best possible medical service available, unanimously opposed the government plan. The united effort of these doctors has now resulted in an unconditional surrender of the government to the doctors, and recognition by the government of the medical profession's plan to provide good medical care and service to the people.

The President's Page

AS I GO ABOUT THE STATE, I am constantly being asked:

(1) What about the Association's request for adopted fee schedules and the new Blue Shield schedule?

(2) What about Social Security for doctors?

(3) What about the proposals for medical care for military dependents?

(4) How much real good comes out of our Committees?

Each of these is important enough for a separate discussion. So they will be considered in following months. The first will be on fee schedules because the House of Delegates specifically requested each County Society to adopt one agreeable to local needs. But I must point out that setting up these schedules is a wearisome and difficult job.

It may save much work if the two existing Blue Shield schedules are consulted and possibly adopted with some suitable local changes.

(1) County or local fee schedules are presently in existence, even if not formally adopted. The changes in each community are a matter of competition, and in general are, by custom, in every-day use. The Blue Shield is facing imperative demands from both industry and powerful unions for a definite scale. They are not interested in the amounts or costs. Blue Shield, which in real truth has the interests of the profession at heart, has proposed a new scale, which is about 50% higher than the present Standard scale. It is substantially above the fees now ordinarily charged, and includes a so-called escape clause. If we do not formulate and adopt this or possibly a higher scale, unions will without doubt set up medical centers. The Lake County Society saw this clearly and asked that we make such centers unnecessary by action before, and not after, their set-up. Any doctor who thinks of the future will agree that such centers will do much harm to the local profession where set up. Preliminary steps have already been taken in at least 3 of our largest centers to build and operate such institutions. We can defeat such movements only by setting up schedules, satisfying the insistent demand for known fees fair alike to patient and physician.

I see no valid reason for failing to set up a local or county schedule. No one is obliged to charge the maximum and anyone may exceed it by simply informing the patient, before service, of a proposed larger amount, if unusual or special conditions so warrant. After all, most of us live on collected fees and efforts to secure realistic and adequate fees are worthy of general

The President's Page — (Continued)

approval. And in event of a depression, such higher schedules, being so-called fringe benefits, are likely to continue even if wages decrease. It then will be easier to provide adequate services at a lower cost to the unfortunate not being helped by such schedules.

Originally, Blue Shield was set up to provide surgical benefits, since surgical charges were most complained of. Obstetrical benefits became an alluring provision, giving the G. P. some recognition. In fact, Blue Shield has always paid out 20% of its benefits for O.B. services, and the proposed new schedule will recognize the value of such services. Since its beginning Blue Shield has had a medical care program which has been bettered by repeated increases. It is now considering a $15.00 first day payment for required concentrated care, plus $5.00 daily for several days before reverting to the $3.00 rate; or a $10.00 first day, plus an increase in the whole daily rates. In addition, it is considering special payments for diagnostic costs, in or out of hospital.

All of these improvements are possible only by County Society acceptance and approval of a schedule.

It is to the advantage of every doctor to have this done, partly because of more realism and in larger part, satisfaction to our people. And these fee schedules should plainly designate the distribution of the amount. The patient is entitled to know who gets what. Then we shall hear no more about fee splits.

Blue Shield continues to be a great experiment in the laboratory of the people of this nation to determine whether, by voluntary means, a great economic problem may be solved.

Blue Shield belongs to you and to your State Association. It is you, magnified 4,000 times. What are you doing to support your own strongest resource? In succeeding months, the other questions will be discussed. Your comments, addressed to me, are invited.

W. H. Kennedy

The Woman's Auxiliary

REPORTS TO I.S.M.A.

All over the state of Indiana during my term in office I have met doctors' wives—women with the same basic problems, the same type of work, the same opportunities. Some are eager to meet these opportunities for leadership in relation to their own groups, their communities, and in the state and nation. The influence of these Ambassadors of Medicine has made the Auxiliary a force for good wherever they are. It is my great desire that all women who have this exclusive privilege should welcome their opportunities and share our good fellowship. We want every doctor's wife to be proud to be a member of the Indiana State Medical Association Auxiliary. If there is no organized group near you join us as a member-at-large and we will keep you informed of the activities at state and national levels. Simply write your President-elect and information will be sent you immediately.

This month we are celebrating our 12th year as a State Auxiliary. Gary, celebrating its 50th anniversary, is proud to be host to the Annual House of Delegates on April 26 and 27. We urge all members and those women eligible to become members to come to Gary and take part in the program.

Sessions will be held in the Hotel Gary with registration starting at 9 a.m., Thursday, April 26. A tour of the steel mills has been arranged for that morning. The board, however, will hold a meeting for all officers at 10 a.m. The planning session for 1956-1957 will be held at 11 a.m. with Mrs. William R. Tindall, president-elect, in the chair.

The first general session will be held in the Crystal ballroom of the hotel from 1 until 4 p.m. on April 26 with the president in charge. All officers will be introduced and present their reports.

The banquet Thursday will be held at 6:30, again in the Crystal ballroom. The Gary Players will present two skits and the Steelmen Carolers will give a musical program. The Indiana State Medical Association will have official representation at the banquet.

Breakfast and a memorial service in the ballroom will start the program Friday. The general session will be continued with committee chairmen giving reports followed by the election of officers.

At noon Friday an April Showers luncheon will be served in the ballroom. Awards will be presented preceding the main address by Mrs. Robert Flanders, Manchester, New Hampshire, President-elect of the Woman's Auxiliary to the American Medical Association.

The installation of officers will follow with Mrs. Charles Voyles, Indianapolis, in charge. The President's pin will be presented to Mrs. William R. Tindall, Shelbyville, by Mrs. J. Winford Mather, Gary. Mrs. Frank Gastineau, Indianapolis, will present the Past President's pin to Mrs. Mather.

Last business before adjournment will be selection of the meeting place for the 13th Annual House of Delegates. A Board meeting will follow adjournment.

Sincerely,

Helen W. Mather

Mrs. J. Winford Mather, President

Independent vs. Joint Fund Raising

ROLLIS S. WEESNER*

Indianapolis

IN MARCH, 1955, the National Board of Directors of the American Cancer Society laid down a flat non-compromising rule that no local units of the Cancer Society could thereafter join any community joint fund raising association such as Community Chest or United Fund Drive. Excepted were only those units that had previously belonged to some such association. The reason for this policy was based primarily on the fact that independent drives in the sole name of cancer control had raised much more money, and at a greater accelerated percentage rate, than had the joint fund arrangements. Also of importance was the fact that public cancer education was potentially greatly reduced through the joint efforts compared to the individual drives wholly in the name of cancer. The Heart Foundation soon followed suit with an identical policy and Polio and Tuberculosis have had such policies for some time.

THE BATTLE RAGES

The proponents of Joint Fund Raising point to the waste of effort, the higher cost and nuisance of numerous campaigns for charitable causes. They do not protest their worthiness but contend that business and industrial methods can get the job done quicker and with less annoyance. They are apt to consider the whole field of philanthropy as a problem that has settled upon us that should be solved with the same acumen that has solved material problems in this age of intense industrial growth—a corporate stock structure, an assembly line, a central control.

The independent drive theory aside from raising more money is based upon free choice and direct control of program and expenditures. The claim that there are not enough people to do the various voluntary health and welfare jobs doesn't quite hold up when we know that 85% of our people have never been asked to help in any way with these efforts and that 45% of Americans, in spite of their generosity, have never been asked to contribute to a single drive including Community Chest and joint fund campaigns. They also contend that bureaucratic control by a small economic minded group may be as onerous as would a government agency, and that their desires and gifts might be surrendered into unsympathetic hands whose gods were efficiency and control.

IS MONEY THE ONLY GOAL?

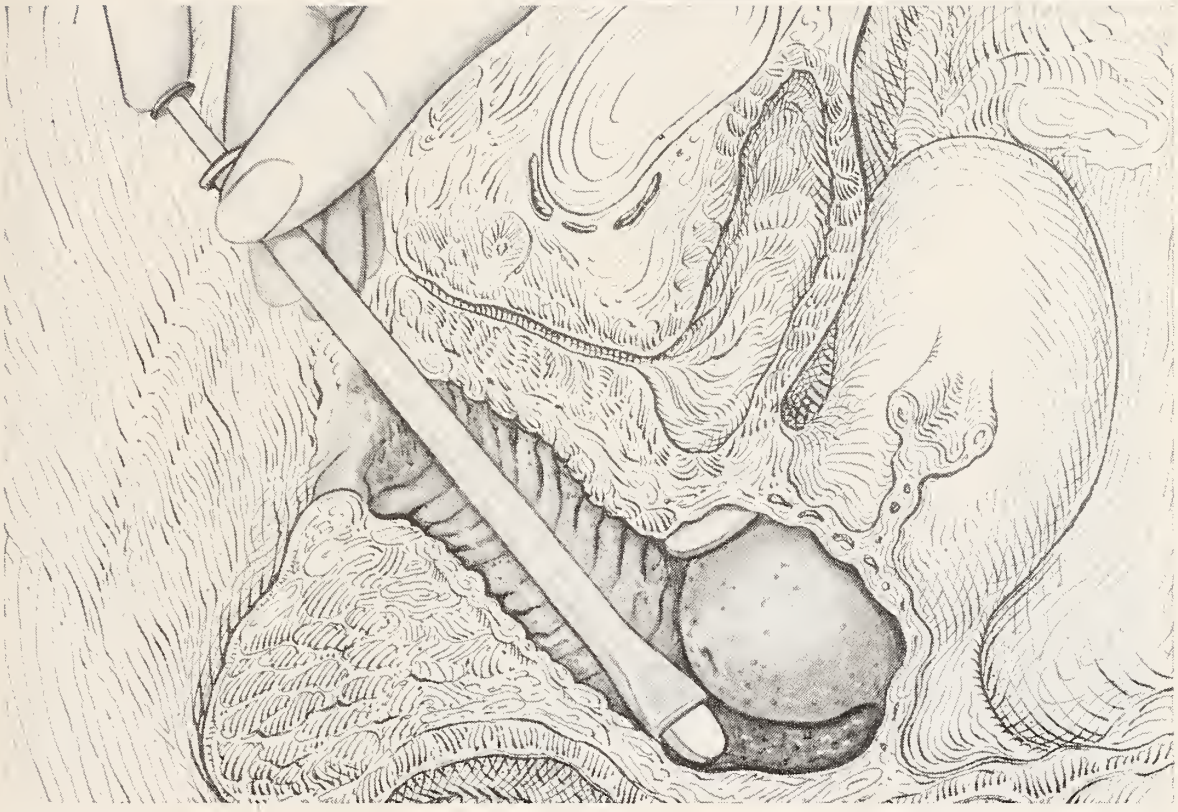
True, it takes money and lots of it to explore and to expand research and techniques in the field of cancer. Progress is being made and no one doubts that the vast sums of money given freely by American people added to that of government and pharmaceutical companies is helping to find the answers. But who can say that money gifts alone were responsible for the successes in tuberculosis control or for the Salk polio vaccine. There was no "Society" for the introduction of insulin or of penicillin, but there has been intense desire on the part of multitudes of people to bring these things about.

Everyone today is hopeful and many fervently prayerful for a cure or preventive for cancer. Most laymen have no way of expressing this desire except through contributions to and possibly some work in the American Cancer Society.

Recently a man who had lost his wife through quick and violent cancer, poured out his heart in reviewing his tragic experience. He had only praise for doctors, nurses and hospital. He was sure everything had been done that could be done. He didn't feel that charges had been ex-

* Executive director, Indiana Division, American Cancer Society.

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cessive and most of all, he had learned the depth of kindness and personal interest that his doctors and others were capable of, not just in the patient, but in *him*. He now wanted some means of expressing his own pent-up emotions toward eradicating the thing that had taken his wife and to help the kindly professional people in their battle against this disease. He was a tradesman, knew nothing of medicine or science and his only release could come through contributing and giving personal service to the Cancer Society.

The technique of impersonal and multi-interest joint fund raising would not give to this man the satisfaction and condolence that the direct striking potential of the independent agency gives.

THE WAY OF COLLECTIVISM

The American birthright of free choice and free enterprise is the backbone of the unique philanthropic attitude of our people. Nations with only one church, a dictator or state collectivism, stagnate and often die. Why should we bow to dictation in one of the most precious things we have—freedom to give where, when, and how we desire.

It is entirely possible that efforts to reduce annoyance, costs and to establish controls in voluntary civic efforts may produce greater cost plus a type of tax collector. In time the voluntary "tax collector" will want to be paid for his services and more and more employees will be needed to plan and enforce the bureaucratic controls and then government takes over and the budgets of the voluntary agencies are put directly on the tax duplicate. A bit exaggerated you may say, but there have been some examples.

The voluntary health agencies are now experiencing, in a way, what the medical profession has been fighting the past two decades, so-called socialized medicine. The proponents of joint fund raising and control of voluntary agencies, unlike the promoters of socialized medicine, are not imbued with political motives. Their public-spirited efforts to streamline the social and health agencies could, however, innocently play right into the hands of the national collectivists.

NOT ENOUGH HANDS

The cry that there are only a certain number of people in a given community who will work on the many voluntary drives and that the same people constantly repeat the canvassing jobs may actually mean that such groups don't want others to get in on the public-attention performances. Follow the "items" in any community newspaper and you find that certain names appear week after week and that 75% of the population is never mentioned. This 75% is seldom, if ever, asked to help in the public service campaigns of the community. They might cherish the opportunity to be recognized and to be offered a chance to prove their good citizenship. These people need releases for the inherent desire within them to perform some public service. In short, the instinct to do good far outweighs the bad. Releases, therefore, are necessary for this expression of spiritual goodness. Joint fund raising tends to narrow rather than expand that opportunity.

We probably need not fewer but more drives and more voluntary movements for the real good they do for the people working in them as well as the causes they serve.

And lastly, maybe one should ponder whether or not any agency or philanthropic movement not strong enough to stand on its own legs is worthy enough to stand at all.



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What Americans Think of the Medical Profession: Report of a Survey

The March issue carried the first instalment of a summary of the survey made for the A.M.A. by an independent opinion and market research firm. To get an answer to the general question "What do Americans think about doctors?" 4,000 interviews were held.

Later instalments will report views of organized medicine and medical economics.

SUMMARY I—PART II

INTERESTINGLY ENOUGH, the survey pointed up a significant fact—that the opinions of doctors themselves about other doctors may contribute to the fact that the medical profession is not as highly thought of as are its individual members.

DOCTOR'S VIEWS ABOUT DOCTORS

Public and doctors agree closely in their appraisals of most doctors on intelligence, capability and willingness to accept medical advances. Eighty-eight percent of the doctors rate most doctors as highly intelligent as contrasted to 98% of the public who say this is true of their own doctors and 93% who say this is true of most doctors. Ninety-two percent of the doctors say most doctors are very capable and this closely parallels the attitudes of the public who indicate that 99% of their own doctors are very capable and that 92% of all doctors are very capable. Eighty-seven percent of the physicians deny that the medical profession is slow to try new drugs and treatments while 72% deny this charge for their own doctors and 64% deny it for most doctors.

Doctor's opinions of doctors generally fall midway between the public's opinions abont their own doctors and about most doctors. On six questions doctors reflect views about their colleagues which represent a position midway between what the public thinks of their own doctors and of most doctors: (1) dedication to mankind; (2) over-readiness to recommend surgery; (3) inability to secure a doctor in an emergency; (4) longer waits than necessary; (5) belief in their own infallibility; and (6) lack of personal interest in patients.

	(Public) My Doctor True	Doctors re Doctors True	(Public) Most Doctors True
Do you think—			
Doctors are not as dedicated to serving mankind as they should be?	6%	23%	27%
Doctors are too quick to recommend an operation?	5%	10%	31%
Doctors are hard to reach for emergency calls?	19%	32%	51%
Doctors keep people with appointments waiting longer than necessary?	15%	27%	41%
Doctors have the idea they are always right?	23%	36%	43%
Doctors do not have enough personal interest in their patients?	11%	21%	39%

But in some instances, doctors are more critical of most doctors than the public is. Doctors are more inclined to say that physicians do not give the patient as much time as the patient would like. However, this may indicate that physicians feel most patients want too much time. Doctors also seem to feel that most physicians are not frank enough in discussing patient's illnesses, that doctors think they are better

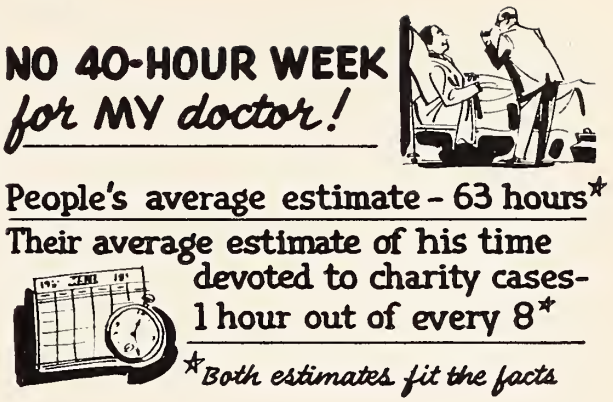
than most people, and that most doctors try to cover the mistakes of other medical men.

Do you think—	(Public) My Doctor True	(Public) Most Doctors True	Doctors re Doctors True
Doctors don't give the patient as much time as the patient would like?	18%	60%	80%
Doctors are not frank enough in talking to patients about their illnesses?	15%	46%	47%
Doctors think they are better than most people?	5%	25%	28%
Most doctors try to hide other doctors' mistakes?	(Not asked)	54%	58%

Only on questions of income and fees do doctors have more favorable opinions of themselves than people have of their own doctors. In three questions pertaining to the economic side of medicine doctors defend their fees. Eighty-six percent of the doctors deny that most doctors plan to get rich quick. Seventy-seven percent of the public deny that their own doctors plan to get rich quick and 52% of the public deny that most doctors anticipate quick financial gain. In regard to fees, 87% of the doctors deny that most doctors charge too much. Seventy-nine percent of the public say their own doctors do not charge too much and 44% say that most doctors' fees are not too high. Only 6% of the doctors think medical service charges have gone up faster than other living costs, but 13% of the public makes this assertion in regard to their own doctors' charges and 35% about most doctors' charges.

Doctors themselves feel they are most appreciated for their competency, sincerity and the healing art. They expect the public to be most critical of their fees, the fact they are not always readily available, and for indifference. When doctors were asked what favorable ideas they think people have about the medical profession, a fifth (19%) say they have no idea of what the public likes about them and 4% deny entirely that people like them. However, 30% say they think people like them best for their competence, intelligence and the healing art. In answer to a question about what unfavorable ideas people have about doctors and the medical profession, doctors overwhelmingly (71%) list

Figure 10



fees as that aspect most likely to come in for public criticism. Yet only 16% of the public think their own doctors' charges are too high. Other aspects which doctors think people might not like so well include: inability to reach a doctor in a hurry (18%); impersonality, coldness and indifference (11%); hurrying patients too much (7%), and incompetence (6%).

It seems evident that the individual doctor needs to form a better opinion of his colleagues and to convey that opinion to his patients. If he himself helps create derogatory impressions of other doctors, he thwarts the public relations efforts of his profession.

OTHER PUBLIC IMPRESSIONS ABOUT DOCTORS

The public recognizes that long years of training are required for the practice of medicine, as well as the fact that most doctors work beyond the 65-year retirement age. People seem to have a good understanding of the lengthy training period necessary to become a physician. The median amount of post-high school training and internship mentioned by the public is nine years and the most common answer is eight years. Some speak of 11 years or more.

A fourth (26%) of the people also say most doctors never retire, a belief corroborated by actual figures in America today. Farm dwellers most often say (35%) that doctors never retire. About 10% of the public say doctors retire between ages 60-64; 20% say they retire between ages 65-69, and 14% say they retire between ages 70-74.

People also have realistic ideas of the doctor's long work week and the amount of charity work done by the medical profession. (Fig. 10) Their average estimate is that their own doctors work

more than 60 hours a week. They list 64 hours as the median estimate of their own doctor's work week as compared to 63 hours for most doctors. Doctors themselves report about the same total working hours.

The public believes that their own doctors give about 12% of their time to charity cases. They make the same estimate for doctors as a group, citing 12% as the median figure. These estimates agree with those of physicians who report a median of 13% of their time is given to charity work, including free clinic time. However, about 40% of the public makes no estimate in regard to doctors' charity work.

Belief that a doctor shortage exists is not as widely held as might be expected. Neither public nor doctors thinks the shortage is self-imposed by the profession. To investigate opinions in regard to the supply of doctors this question was asked: Would you say there are too many doctors in this part of the country, about the right number, or not enough?"

	Public	Doctors
Not enough	53%	20%
About the right number	39	58
Too many	2	18
No opinion	6	4

Two-fifths of the people compared with three-fourths of the doctors say there are enough or too many doctors in their area. Farm residents are most inclined (64%) to believe there are not enough doctors in their part of the country. Residents of the West (42%) and of medium-sized cities (43%) least often say this. The need for additional doctors is felt most often by those physicians practicing in the southern (26%) and central (28%) states and in smaller towns (31%) and by general practitioners (27%).

The charge that the medical profession (or A.M.A.) tries to hold down the number of physicians was denied by both the public and the profession. Only 12% of the public and 7% of the profession think the medical profession does try to limit the supply. Forty-four percent of the people say the medical profession or the A.M.A. tries to get more doctors and 33% of the doctors asserted this was true. The highest proportion of doctors who say the A.M.A. tries to restrict the number of doctors are found among non-members and doctors who do not like A.M.A.

People correctly estimate the degree of medical specialization today and less than half of the public criticizes this trend. The public does not necessarily consider specialists to be more capable than general practitioners are. The median estimate of the public is that about one-third of all doctors are specialists. This agrees closely with the actual proportion of full-time specialists —36%, according to the A.M.A. Bureau of Medical Economic Research. When asked whether most doctors were becoming too specialized, 47% of the public say it is true as against 34% who say it is false. A larger percentage of physicians (57%) say they think most doctors are becoming too specialized. Criticism of over-specialization comes most often from general practitioners (70%). Smaller proportions of the specialists agree: 51% of the internists, 48% of the surgeons, and 46% of the other specialists.

In answer to the question, "Which kind of doctors do you think are most capable in the work they do—general doctors, surgeons, or other specialists?", surgeons receive a slightly higher rating by the public with general practitioners scoring a close second:

Surgeons	29%
General doctors	24
Other specialists	20
All about the same	16
Qualified answers	1
No opinion	10

Westerners most often (24%) say that other specialists are the most capable. Retired persons and others with no workers in the family give the general practitioner the highest credit (30%) on this score. Easterners most often (21%) say that all are equally competent.

Most people see their own doctor as someone special and think that choice of physician is of great importance today. The public apparently believes that choosing a physician is more important today than it was 20 years ago. Fifty-eight percent say it matters a lot these days as opposed to 44% who say it mattered a lot 20 years ago. The only groups in which less than the majority agree are non-whites (46%), people who never entered high school (49%), and people who have no family doctor (48%). The special groups, except the pharmacists, are even more convinced that choice of a physician is important—67% of the editors and commenta-

(Please turn to Page 428)

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1. Cronheim, G., and Toekes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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tors, 71% of the lawyers, 75% of the nurses, 67% of the medical society executive secretaries, and 57% of the druggists say choice matters a lot.

Those who say it matters a lot list these reasons for their answers: abilities, training, equipment, confidence, sincerity, acquaintance with the patient's past history, congeniality, personality, and interest. Those who say choice is not important are more inclined to say it doesn't matter because all doctors have the same education and qualifications and that one is as good as another.

A third of the public offer recommendations for physicians, mostly for doctors as individuals. The suggestions of the public tend to emphasize the traditional concepts of the family doctor. Here are answers in reply to this question: "Have you thought of anything that the medical profession or individual doctors could do to get along better with the public? What?"

Make themselves available, come when called	6%
Lower their fees	5
Take more personal interest	5
Be more friendly, more sociable	4
Be honest and frank on illness and fees	3
Don't rush patients, take more time	3
Keep their appointments better	2
Inform the public, public relations	2

According to the survey, family doctors are highly regarded by their patients, and doctors in general are looked upon favorably, although not as favorably as are personal physicians. Areas of public dissatisfaction are almost entirely in the economic realm.

PROFESSIONAL FILMS ON CANCER AVAILABLE

The Indiana Division of the American Cancer Society has the following scientific films for loan to any professional group in the state. They are in sound and color and highly authentic. Running time approximates 30 minutes for each. Make requests to American Cancer Society, Indiana Division, 325 Board of Trade Building, Indianapolis 4, Ind.

1. Cancer: The Problem of Early Diagnosis.
2. Breast Cancer: The Problem of Early Diagnosis.
3. Gastro-Intestinal Cancer: The Problem of Early Diagnosis.
4. Uterine Cancer: The Problem of Early Diagnosis.
5. Oral Cancer: The Problem of Early Diagnosis.
6. Lung Cancer: The Problem of Early Diagnosis.
7. The Exfoliative Cytologic Method in the Diagnosis of Gastric Cancer.
8. What is Cancer? (Nurses).

Kinescopes: (running time approximately forty minutes)

Lymphomas and Leukemias.

Cancer of Urinary Bladder.

Lung Cancer.

Recommended for Lay Groups (running time approximately eighteen minutes):

Breast Self-Examination (Lay Education)

The Warning Shadow (Lay Education—Lung)

Career: Medical Technology (Recruitment)

Absenteeism and Auto Safety High on Agenda at Industrial Health Meeting

AN UNUSUAL ACTION on the question of work absence statistics climaxed the 16th annual Congress on Industrial Health in Detroit, January 23-24.

The meeting, sponsored by the American Medical Association's Council on Industrial Health and five other organizations, drew nearly 500 leading physicians, ranking medical officers of the armed forces, medical directors of major industries, nurses, and heads of departments or deans of universities engaged in industrial health study.

At the close of the two-day program, participants unanimously voted agreement with a suggestion that the Council and the A.M.A.'s committee on medical care for industrial workers map a plan for gathering work absence statistics and issuing periodic reports on them for industry's guidance.

The suggestion was made following a panel on absence from work due to nonoccupational illness and injury. One of the items discussed was a new syllabus on work absence which was made available to all participants. Written by Mark S. Blumberg, M.D., and James Coffin, A.B., under the direction of the U. S. Public Health Service occupational health program, the syllabus is intended as a basic reference on the subject.

"WILLING AND ABLE"

Dr. Lemuel C. McGee, medical director of the Hercules Powder company, Wilmington, Del., cited the first line of the syllabus as support for the theory that there are many categories of unpreventable absence: "A worker on the job must be both willing and able to be there; if one of these conditions is not satisfied, he will be absent."

He said medicine may have placed too much stress on "willingness to work" because of "its chagrin at not being able to prevent such absence-causing disabilities as the common cold."

However, he pointed out that absence may be elective or constructive (such as for surgical correction of defects, or for prevention of contagion), while many fluctuations in absence rates may be due to other non-occupational-illness causes. For instance, during high prosperity periods when jobs are abundant, absence increases.

Dr. Frederick Slobe, Chicago, Blue Cross-Blue Shield medical director, emphasized that control of absence is not the sole purpose of the industrial medical department. This is largely an administrative problem, he said, and the department should not be a "policing agency" for work absence due to non-organic causes. He said the department should, however, serve as advisor and counsellor on this problem.

Dr. Slobe pointed out a recurring theme of the discussion—the importance of referral to private physicians, and of liaison with them.

OLDER WORKERS NOT CHIEF ABSENTEES

One fact which should be stressed is that older workers are not the major contributors to absence they have been believed to be, according to Dr. A. Hazen Price, a University of Michigan professor who is consultant to several large corporations. However, Dr. Price said older workers need to be eased into retirement and helped in their adjustments, as a major preventive against chronic disability. Yearly evaluation of individuals is needed, to stave off the physical and mental deterioration which results when the older worker faces a fixed retirement date.

Mental and emotional problems were flatly named as greater causes of absence than any occupational disease or accident, by Dr. Frank A. Calderone, public health administration, Long Island.

Dr. Calderone said true reduction in total absenteeism will occur when management, labor and industrial medicine allow the industrial medical service to do its proper job of preven-

tion and counselling, thus enabling it to help the worker achieve and maintain the highest level of emotional and physical well being.

The annual award given by the President's Committee on Employment of the Physically Handicapped was presented to Dr. Gradie R. Rowntree, medical director of the Fawcett-Dearing Printing Company, Louisville. Signed by President Eisenhower, the award was given to Dr. Rowntree by Maj. Gen. Melvin J. Maas, USMCR, retired, chairman of the President's committee.

One of the high points of the meeting was the award talk given by General Maas, who has been totally blind for four years and suffers arthritis and diabetes. During the past year he has travelled some 100,000 miles in the committee's work to get jobs for the handicapped and "restore to them their dignity."

In overseas travel, General Maas said he discovered the work of the committee was "an impressive argument against Communism, with more appeal to Communist-threatened people than Communist promises of autos, roads or even hospitals."

"These people learn about what we do for handicapped people and they say 'if you do this for the least of yours, the crippled and sick, then your way of life is what we want,' " he said. "Their craving, above all else, is to have their dignity given back to them."

HESS AND FORD IN FRIENDLY DEBATE ON AUTO SAFETY

One of the most striking features of the meeting was the discussion of auto accidents and safety, particularly the talks by A.M.A. President Elmer Hess, M.D., Erie, Pa., and Ford Motor Company Vice President Benson Ford, Detroit.

Participating in a panel on "Medicine's Responsibilities in the Automotive Age," Dr. Hess suggested several steps toward reducing the "sordid" highway accident toll, including tougher driver license requirements with interstate standardization, stricter law enforcement, standardized safety improvements in automobiles, and a national research institute on safe driving.

While complimenting the auto industry on its recent efforts to add safety features, Dr. Hess criticized its emphasis on power and "sizzling take-off." He said the industry should "make itself responsible for producing machines which do not tempt men to make fools of themselves."

He also said safety features should be standardized throughout the industry so that "the lives of Americans are not subject to dollar competition."

Speaking at the annual banquet, Ford disagreed with Dr. Hess on several points. He said he felt the development of safety equipment would advance more rapidly if kept highly competitive, so that industries would vie with each other to produce the safest cars.

He also defended the industry's efforts to increase horsepower. The growth of power has not been matched by an increase in top speed, he said, and horsepower is itself a safety feature since it allows faster action in escaping hazardous situations.

Outlining a number of safety devices now standard in most cars, Ford said the industry has been going slowly on several proposed features because there is not enough evidence that they actually would be effective.

He said that "unfortunately, there is a shortage of the cold scientific evaluation and fact finding that we need in order to progress as fast as we should like in reducing the injury potential of the automobile interior."

Noting that the medical profession has recently entered more actively into cooperation on accident prevention fact-finding, such as the Cornell University research, Ford urged that doctors devote even more attention to these efforts.

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(1) Poyne, R. W.; Shetlor, M. R.; Forr, C. H.; Hellboum, A. A., ond Ishmoel, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Willioms, R. R., and Block, R. L.: J. Chron. Dis. 1:168, 1955. (3) Holbrook, W. P.: M. Clin. North Americo 39:405, 1955.

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I.U. Medical Center Expands Residency Training Program in Psychiatry

THE INDIANA UNIVERSITY School of Medicine is offering appointments in a three year approved and recently expanded residency training program in psychiatry on the Indiana Medical Center campus in Indianapolis. Actively participating training units include the LaRue D. Carter Memorial Hospital, an acute treatment center for 200 adult and 50 children inpatients, under Dr. D. F. Moore, medical director; the Tenth Street Veteran's Administration Hospital with 116 psychiatric beds under Dr. E. G. Fogel, chief of neuropsychiatry; and the Indianapolis General Hospital with 56 adult psychiatric beds under the supervision of the department staff members. All residents rotate during training through the University Child Guidance Clinic and the psychiatric outpatient clinic with consultation services under senior supervisors in three of the university hospitals. Both inpatient and outpatient clinical work are under the close personal supervision of qualified therapists. A varied curriculum of didactic conferences and seminar activities is also provided by the clinical hospital staffs and full-time members of the Department of Psychiatry, with intimate participation also by members of the Department of Neurology and ancillary branches. In the senior years of training excellent opportunities for supervised research are provided within the hospital services and are now being rapidly expanded through inter-disciplinary staff activities in the new Psychiatric Research Institute shortly to be opened. For those interested and qualified, teaching opportunities are provided for the instruction of medical students in their psychiatric training and for the instruction of those in affiliated training programs in the social sciences.

The stipend for the first year of training is $4,380, the second year $4,800 and the third year $5,760. Opportunities are also available for fourth and fifth year appointments leading to permanent departmental staff positions in both the clinical and research fields.

Further information may be obtained directly from John I. Nurnberger, M.D., Chairman, Department of Psychiatry, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

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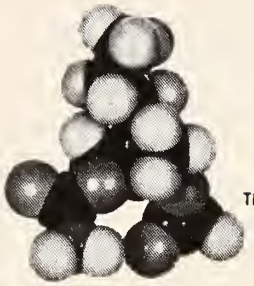
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1. Selling, L. S.: J.A.M.A. **157:** 1594, 1955. **2.** Borrus, J. C.: J.A.M.A. **157:** 1596, 1955.

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Writing for the Reader

DAVID A. BICKEL, M.D.

South Bend

THE WORTH of any scientific writing is the information it conveys to the reader. If the author's ideas are to be carried smoothly across the pages to the reader, his writing must be easily readable. Medical writing meets critical and sensitive readers. Not all readers read equally well. Some get ideas readily, others do not. Because the flow of medical literature is so vast, even the conscientious physician must skim lightly this immense reservoir of medical knowledge. There are now over 1,500 medical journals in the United States which publish original articles, and new journals are appearing every year. This number does not include bulletins, abstract digests, or commercial publications. Much inert material is included in this bulk.

The purpose of this communication is not to present a treatise on medical writing, but a synoptic view of the subject which may be helpful to any physician who is writing a medical paper. And in the main, the ideas expressed are those of leading language authorities and medical editors.

WHY PHYSICIANS WRITE

There is a demand for physicians who can write well. But few physicians are so gifted or have the time to spend at a pursuit which is not strictly the practice of their profession. Nevertheless every physician should know how to prepare a paper or a case report to be presented at a medical meeting, or be published. Unless a speaker is repeating the address he has given many times, or has slides or reels which fully present the subject, his reading from a well-written paper will be appreciated by his audience, and his paper will be available for publication.

There are several reasons why physicians write, and why they should write:

(1) Medical writing is the chief medium of dissemination of medical knowledge, and essential to the advancement of medicine. Therefore one who has made a new discovery, an important clinical observation or has developed a new technique or even observed an unusual or interesting case, has the moral obligation to pass such information on to his colleagues. Medical writing for the profession cannot be regarded as a source of profit.

(2) Another motive for medical writing is that the writer himself thus obtains new knowledge by the review of a particular subject. The amount of medical literature which must be read in the preparation of a paper has unquestionable educational value for the author. Medical writers have been known to write papers solely for the purpose of reviewing subjects in which they were interested.

(3) A physician may enhance his professional prestige by writing a paper to read at a medical society or to be published in a medical journal. Writing papers is one of the few ethical ways for a physician to promote himself.

(4) A few physicians write for compensation. Some write columns and articles for popular periodicals, and others are employed by pharmaceutical firms to do promotional writing. There is an increasing demand for physicians who can produce popular writing.

(5) A number of physicians write for the sheer enjoyment which they derive from it. If

Presented at the first meeting of the South Bend Medical Round Table, November 18, 1955.

one develops, by practice, a competence in writing, he will be amply rewarded by his commensurate pleasure and satisfaction.

WHY PHYSICIANS DO NOT WRITE

Although there is a plethora of medical writing, it is stated frequently that few physicians have the ability to express themselves clearly and concisely. For most physicians—although they are no less cultured than other citizens but are busier than many—getting started to write is a painful task. To undertake writing requires drive, energy, hard work, and more time than many busy physicians have, yet if one wants to learn to swim he must get into the water. A journalist may write a news item or an editorial in an hour but a busy physician cannot write a medical paper in a week, because it requires reading which he must do in his spare time. But it is undeniable that if a physician is to be known outside his immediate community, he must produce some medical writing, or engage in medical politics. British physicians write better than we Americans do. They undoubtedly have a sounder literary background and a better basic training in English composition. Medical educators are cognizant of this situation and are taking measures to correct it. Courses in medical writing have already been instituted in the journalism departments of a few universities. To employ a ghost writer is dishonest and very likely to get the pseudo-author into an embarrassing situation.

There are several reasons why many physicians do not gain proficiency in writing:

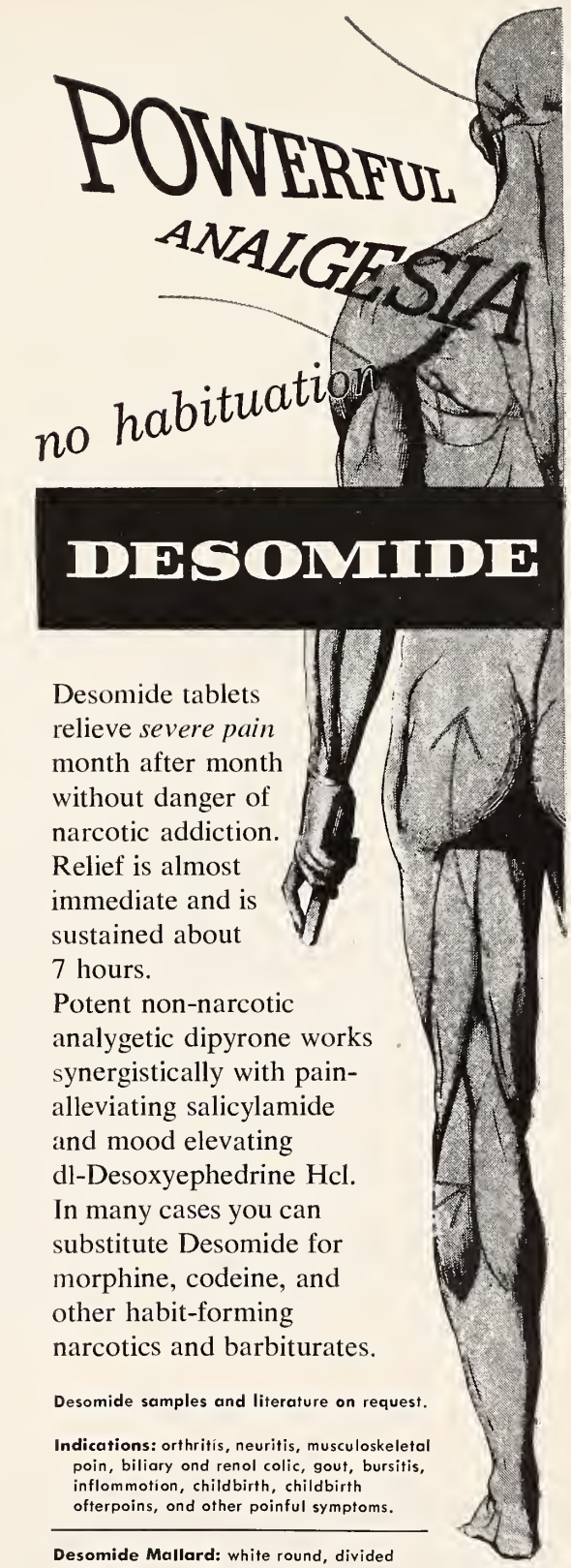
(1) Language is not thoroughly taught in elementary schools, high schools and colleges.

(2) The medical student cannot devote time to learning to write because he is preoccupied with the acquisition of prescribed scientific facts.

(3) There is no opportunity for the essay type of writing in medical school. Fill-in history blanks, true-false and multiple-choice tests have replaced the essay type of examination. Research work and essay writing are not required of hospital residents.

AN ACCEPTABLE PAPER

Only a small portion of the papers offered to editors of the better medical periodicals are accepted for publication. *The Journal of the*



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American Medical Association receives over 3,000 manuscripts a year, but has space for the publication of only 600 original articles. The editor of a periodical must be convinced that an article contains worthwhile information and is readable. The editor's concern lies in the interest of the reader and the reputation of his journal. Few physicians have the good fortune to report a great scientific discovery, but many have made some important clinical observations, or observed an unusual case. A review of the literature on a particular subject is sometimes valuable if such a review has not been recently made. But a rehash of the same observations or studies which have been reported repeatedly and recently is not usually acceptable as a contribution. If the elements of language, such as spelling, syntax, grammar, and punctuation are not correct, an editor may surmise that the reported observations in the paper are equally faulty. To offer for publication a paper containing jargon, verbosity, slang, fancy writing and/or colloquial English, is like applying for a job unshaven, with baggy trousers, and with gravy on your necktie.

PRELIMINARY READING

When the author has chosen a subject, the next step is to peruse the literature on that subject. Textbooks are useful as guides only. The literature on a particular subject may be obtained through the Quarterly Cumulative Index Medicus, the Index Catalogue of the Armed Forces Medical Library, and the Current List of Medical Literature and comprehensive abstracts of journals, as well as the bibliographies and references of recent articles. If the author does not have access to a medical library, the library services of the American Medical Association, the American College of Surgeons, and the Armed Forces Medical Library are available. The author himself should record the references. Frequently when the writer reads the literature on his chosen subject, he finds that recently one or several writers have published the material he is intending to write. He had better not write on that subject. At the time of the preliminary reading, a complete reference should be kept with recorded notes and excerpts. This reference material is best transcribed on cards or sheets which can be arranged alphabetically.

OUTLINE

An outline is to writing a paper what a plan is to building a house. If a paper is to have the fundamentals of good writing, unity, coherence and clarity, it must be written from an outline, or better, from two outlines, an outline of headings for orientation, and a detailed outline, which includes all the ideas the author wishes to present. The extent of the outline will vary with the type of paper being written. The textbook plan of outlining a paper by sections, such as introduction, history, etiology, pathology, symptoms, treatment, and prognosis is obsolete, boring and repetitious. Each type of paper should have a definite purpose, and the writer should show individuality in its composition. But whatever type of paper one chooses to write, an outline is essential in order to avoid omissions and repetition and to present the important points of the paper in an orderly fashion.

The Title—The title of a paper should be as accurate and as attractive as the author can make it. Accuracy of the title is required for the indexing of the article and if the title is attractive it will draw the reader's attention to this article. A title should not be over 60 letter spaces. If much material is desired in the title, a subtitle

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may be used. Vague titles such as "Hemorrhage", "Review of 1,000 Obstetrical Cases", "Experiences of a Neurosurgeon in a Midwestern Town" cannot be accurately indexed and will not attract many readers. The title of a paper is in a competitive position, because it must catch the wandering eye of the reader who scans a vast amount of medical literature but has time to read only a small portion of it; it is the show window. The title need not be chosen until after the outline is prepared or the first draft of the paper written.

The Introduction—The introduction and the summary are the parts of a medical article most frequently read. If these parts of the article are attractive, readers may be enticed to read the entire presentation. The lead sentence is the most important sentence in a paper. It should contain no more than 20 words and should give an idea of what the author is writing about—few other sentences in a paper should contain more than 30 words. The reader is usually lost after 40 words because he does not know when any statement is completed. The type of introduction may be historical, definitive, expository, statistical, or philosophical. Or, if one is a seasoned writer—there are few—he may open his presentation humorously, dramatically, or by a story. Whatever the type of introduction, it should be brief but it should adequately introduce the forthcoming discussion. One editor has stated that 90 per cent of manuscripts would be improved by cutting off the first page or the first paragraph.

The Body of the Paper—The body of the paper should contain the original material to be presented, and should comprise all of the discussion except the introduction and summary; it is the reason for writing the paper. Headings and subheadings make an attractive page and render the material more readable by enabling the reader to quickly find the points in which he is most interested or to which he may wish to refer. If headings are used, all material included under one heading should belong to that phase of the subject.

Information may be effectively conveyed in medical writing by methods other than the printed page. Carefully constructed tabulations and diagrams may be liberally used, and should be self-explanatory. A diagram which is not understandable on sight serves no purpose. Hospital charts cannot be satisfactorily reproduced. The graph is commonly used in scientific writing because the use of horizontal and vertical coordinates can be incorporated in a variety of diagrams. Pie and solid or shaded bar diagrams are also frequently used and convey much information on sight. If any diagram is used, the scale must be correct lest an erroneous impression be created. When a manuscript is presented for publication all tables should be typewritten on separate sheets and checked with the text for accuracy. If illustrations are to be used, they must be glossy prints with legends typewritten on separate sheets. Most publications, because of cost and space, limit the number of illustrations. When a procedure is described it should be done with a minimum of detail, eliminating nonessentials and avoiding duplications, but accuracy should not be sacrificed for brevity. In any report of clinical observations, controls are necessary; this particularly applies to therapeutic measures. Uncontrolled reports of "cures" of colds or vomiting of pregnancy could make the reader question the soundness of the author's observations.

One of the hazards of medical writing is the presentation of clinical or laboratory data by the statistical methods. Medical statistics may be misinterpreted even by the author himself. If one is writing material supported by statistics, he should consult one of the works of some expert on that subject.

In medical writing, it is important not to change tenses. The past tense is used except where the author is reviewing the literature of one year, in the discussion of work being presently done or in the summary of a paper.

Summary and Conclusions—After a glance at the title and a few introductory sentences of a medical article, most readers will turn to the summary, and if it is interesting they may read the entire article. Both summary and conclusions are not always required. The summary should have meaning and give briefly the important points expressed in the paper; it is to describe the article and not repeat what was said. The reader wants to know what was done, why, and with what results. The conclusions should enumerate the deductions from the clinical or experimental observations reported in the paper. The author should not hesitate to express any well-

founded conclusions derived from the study which he is reporting. It has been stated that medical writers are too reluctant to express conclusions arrived at from their studies.

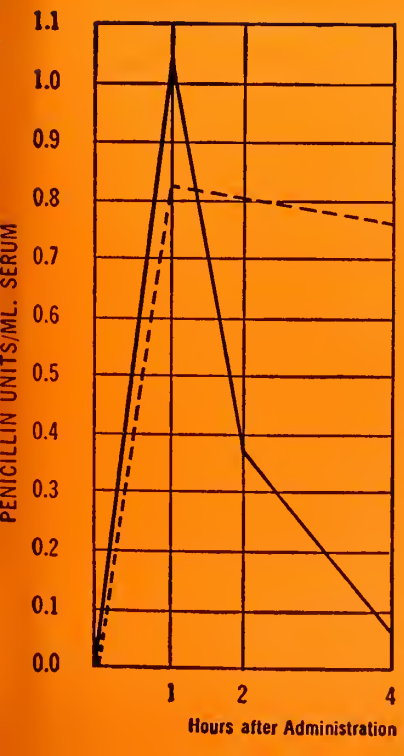
STYLE

Style is an elusive quality of language which consists of saying what you want to say as clearly and exactly as you can say it. How does one acquire style? The beginning writer acquires style first by reading the works of good writers, (2) by writing and rewriting. There are some styles that the writer should try to avoid, and one should never attempt to write when he is tired, elated, or angry. If the medical writer feels inclined to flights of literary fancy, he should write it in the first draft and delete it at the first revision. Pompous or flabby writing and verbosity are not likely to be read. One should write what he has to say in short compact sentences with short words as simply, emphatically, and clearly as he can. But every writer is entitled to his own style of writing. Osler's *Principles and Practice of Medicine* is an outstanding specimen of fine medical writing. There are certain basic principles of all good writing (Quintilian's precept: "One should write not only that he should be immediately understood, but that he could not possibly be misunderstood.").

CASE REPORTS

Case reports should be brief and contain only the information necessary to give the reader a vivid clinical picture of the case. A single case report may be the purpose of the entire paper; a brief review of the recent literature should precede such a report. If a number of cases are reported, reports should be especially brief; lengthy descriptions of negative tests and examinations, unless they have definite bearing on the case, should not be included. The patient's initials, hospital number, and the name of the hospital in which he was treated, serve no purpose and should not be included—but the author should keep a record of such information for identification. Case reports should be written in the past tense. Calling the patient a case is a

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common error. The case report is the complete story of an instance of disease, and the patient is not a case but a person with disease.

REVISION OF THE MANUSCRIPT

There is as much difference between the first draft and a revised manuscript as there is between crude oil and high-test gasoline—and reading an unrevised manuscript is as disagreeable as running a car on crude oil. Few writers, if any, write what is satisfactory to them or their readers on the first draft. Robert Louis Stevenson, William Osler and Harvey Cushing revised their writings as many as 12 times. Herbert Hoover rewrites his papers many times; it is evident. After the first draft of the manuscript has been set aside for a few weeks, it is ready for revision, and then frequently the writer himself may not believe he wrote it. At the first revision of a paper it should be cut at least 25 per cent, and the parts of the paper should be arranged in proper proportions. Such defects as a long introduction to a short presentation can be corrected. Also at the first writing many important facts may have been omitted; these can be added during revision.

Words—Much of the revision of the manuscript is the selection of not only correct but choice words. A word may be correct according to a dictionary and yet fail to convey a ready and concise meaning. Every word helps or harms. A word should be national, current, translatable, and in good taste. Sentences should make the language, but words make sentences; and without the right words the sentences do not clearly communicate the ideas of the author to the reader. Mark Twain said, "The difference between the right word and almost the right word is the difference between lightning and the lightning bug". The author may be able to select the right words (1) by reading well-written literature, and (2) by the consistent use of an unabridged general dictionary, a modern medical dictionary, and one of the many works on synonyms. The dictionary is the writer's most important reference book; it has been a lifelong friend of all good writers and speakers.

A few suggestions on word selection are:

1. Only standard English words and phrases should be used. Language is not static; new words and new connotations of old words are constantly appearing, but language authorities should introduce the newcomers. "Generalist", a physician who does not claim to be a specialist, is a new arrival, but too new to be used in formal writing.

2. Medical jargon, colloquialism, and slang may not be intelligible to every reader, and their translation is often impossible. Besides, the use of undignified language marks the author as one who is uncultured and uneducated and his work probably substandard. Some characteristic samples of medical jargon are "milligrams per cent", instead of "milligrams per 100 cc.", "doing an appendix", instead of "performing an appendectomy", a "primip", in place of a "primipara", "chronic ear", for "chronic otitis media", "orthopod" for "orthopedic surgeon", and "specific" for "syphilis". Adjectives should not be used as nouns. Patients, for example, are not cardiacs or diabetics. Nouns should not be used as verbs unless their use has been generally accepted. Patients are not cystoscoped, rectoscoped or cardiographed, and abstract words ending in "ology", which designate branches of medical knowledge, are not to be used in a concrete sense; the patient does not have pathology, cytology, or hematology.

3. Adjectives should be used sparingly and only to add precise emphasis; strong and concrete adjectives are preferred.

4. Foreign words and phrases should be avoided if there are English words to express the same meaning. When foreign words are used they should be translated, and when conventional Latin words are used, the form should be correct.

5. Familiar root words are preferred to words carrying many affixes; root words in short sentences make for easy reading. Many people read the Bible because it is written mainly with root words. Nevertheless in scientific writing the use of a certain number of long scientific words is often necessary and one should not attempt to make a scientific paper merely popular reading.

6. Eponyms, or proper names, connected with medical terms should be avoided, whenever possible, to avoid confusion. There are two Paget's diseases and four Pick's diseases, for examples.

7. Concrete nouns and active verbs should be used in preference to abstract nouns and verbs in passive forms.

8. Verbosity, the unnecessary and extravagant use of words, and circumlocution, which

means making indirect statements, renders writing relatively unreadable. Such phrases as: "I believe", "it is our opinion", "it is common knowledge" are unnecessary. The repetition of such words as "very", "marked", and "great" and overworked phrases commonly used in medical writing and speaking are to be avoided.

9. Scientific terms should be those included in official lists recommended by scientific organizations, such as the Standard Nomenclature of Diseases and Operations, Basel Anatomical Nomenclature, The International List of Causes of Death, and the terminology of the Council on Pharmacy and Chemistry of the American Medical Association.

10. Abbreviations may be used for words which have previously been spelled out. But abbreviations which are hard to decipher or not generally used should be avoided. Not everyone knows that "B. O. W." beans bag of waters and that "S. O. B." means short of breath, and that "S. O. S. B." means sit on the side of the bed.

FINAL REVISION

The number of times a medical paper should be revised depends on the literary ability and experience of the author. But it should be revised until the author considers it as nearly perfect as he can make it. The final revision affords an opportunity for a final check on spelling, accuracy of statements, and punctuation. It is not within the scope of this presentation to discuss in detail the rules of punctuation. A rough check for stops in writing is to read the paper aloud and determine where pauses should occur. Most medical writers use the comma too frequently, and not sufficient other punctuation, particularly the dash and parentheses.

SPECIAL FEATURES

Bibliography—A bibliography includes everything of importance that has been written on a subject. The list should be arranged alphabetically according to the names of the authors or chronologically. If a bibliography is to be added to an article, the author must be sure that it is complete. It should contain the important and strictly original articles on the subject. Yet such a complete listing of the literature is seldom necessary unless one is making a comprehensive review of a subject. If an adequate review of a subject has been made recently, the author may refer to that particular review instead of appending a complete bibliography. Bibliographies have one important purpose—that is to direct research workers to significant available information.

References—In preparing most papers it is necessary to cite only the literature referred to in the text, or from which information concerning the subject has been obtained. When excerpts from references are quoted, they should be placed in quotation marks and permission for quoting obtained from the publisher and ac-

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*Lawrence, W. E.; Kahn, S. S., and Riser, A. B.: South. M. J. 47:105, 1954.

knowledged. All references should be read by the author and not be copied from other articles.

When a reference is cited in a scientific paper it should be exact and complete. If a reference is to a book it should contain the following information in this order:

1. Surname and initials of author.
2. Title of book.
3. Edition.
4. Place of publication.
5. Publisher.
6. Year of publication.
7. Volume, if more than one has been published.
8. Pages referred to.

If the reference is an article from a periodical it should state in the following order:

1. Surname and initials of author or authors.
2. Title of article.
3. Officially abbreviated name of periodical, according to the *Quarterly Cumulative Index Medicus.*
4. Volume.
5. Page, or pages referred to.
6. Date of publication. Month and day of month if periodical is published more than once a month, and the year of publication.

Journals vary somewhat in the manner in which they list references. Most publications list them in the order in which they appear in the article; a few journals list them alphabetically. In some journals all of the pages of an article are listed; others list only the first page; some include the month, or day of the month, others only the year. When the author knows in what journal he intends to publish his work, he should list his references according to the fixed convention of that publication.

MULTIPLE AUTHORSHIP AND ACKNOWLEDGMENTS

Multiple or co-authorship has become a problem for medical editors. Much research work is done in teams and each member expects to have his name on the article. It is the opinion of most medical editors that only those who did actual creative work and had part in the writing of the paper should be considered as authors of an article. If many names appear as authors it lends no prestige to any one individual, and interferes with cataloging of the article. The names of those who made some contribution to the work but did not take a major part may appear as acknowledgements in footnotes, but editors of many journals disapprove of a lengthy list of such footnotes.

SUMMARY

With modern means of communication like sound transmission, film projection, and television, the present bulk of medical literature and the number of publications are more than adequate. But truly informative and readable medical writing will still find its readers. So when the physician thinks he has something worth writing (collected facts or a thought-provoking problem), he should make a preliminary survey of the literature to see how much about the same subject has been written recently. If he considers his material important or timely he should



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write it as clearly and briefly as he can, and revise his manuscript many times.

To possess knowledge is one thing; to impart it is another.

APPENDIX

The following reference works are recommended to the medical writer:

American Medical Association: Standard Nomenclature of Diseases and Operations, ed. 4, Philadelphia, Blakiston Company, 1952.

American Medical Writers' Association: Annual Symposia and Quarterly Bulletins on Medical Writing.

DeBakey, Selma: Suggestions on Preparation of Medical Papers, J. A. M. A. 155:1573-1577 (Aug. 28) 1954.

Fishbein, Morris: Medical Writing, ed. 2, Philadelphia, Blakiston Company, 1948.

Flesch, Rudolph: The Art of Plain Talk, ed. 5, New York, Harper & Brothers, 1946.

Gowers, Sir Ernest: Plain Words, New York, Alfred A. Knopf, 1954.

Howie, J. W.: On Writing to be Read, Lancet 2:320-321 (Aug. 25) 1951.

Jordon, E. P., and Shepard, W. C.: Rx for Medical Writing, Philadelphia, W. B. Saunders, 1952.

Mainland, D.: Elementary Medical Statistics, Philadelphia, W. B. Saunders, 1952.

Perrin, P. G.: Writer's Guide and Index to English, ed. 2, New York, Scott, Foresman & Company, 1950.

Thomas Payne, E. L.: A Guide for Authors, Springfield, Ill., Charles C. Thomas, 1949.

Wesson, M. B.: Writing a Medical Paper: Why and How, J. Urol. 65:507-512 (April) 1951.

Libraries from which bibliographic material may be obtained:

American Medical Association, 535 North Dearborn St., Chicago 10, Ill.

American College of Surgeons, 40 East Erie St., Chicago 11, Ill.

Armed Forces Medical Library, 7th St. and Independence Ave., S.W., Washington 25, D. C.

Interlibrary Loan Service:

The John Crerar Library, 86 E. Randolph St., Chicago 1, Ill.

Medical Manuscript Editing Service:

American Medical Writers' Association, 209-224 W.C.U. Bldg., Quincy, Ill.

Norbert Engels, 810 Napoleon Bldg., South Bend, Ind.

Mrs. Natalie J. Hoyt, 122 E. 92nd St., New York 28, New York.

Deaths . . .

George H. Van Kirk, M.D., 76, Kentland physician and surgeon for more than 50 years, died in St. Elizabeth's Hospital, Lafayette, February 14. Although ill for several months he was hospitalized for only one day.

Dr. Van Kirk was a native of Fulton county. He received his medical degree from the University of Illinois College of Medicine in 1905 and established his Kentland practice soon afterward. He was on active duty and an officer in the Indiana National Guard for many years. Dr. Van Kirk served overseas during World War I and at a base hospital during World War II until his retirement from the Medical Corps as a lientenant-colonel. He served as a member of the Kentland school board for 16 years, was Newton county health officer for many years, and a surgeon for the New York Central Railroad.

Dr. Van Kirk was a senior member of the Jasper-Newton County Medical Society, a Fifty Year Club member of the Indiana State Medical Association and a member of American Medical Association. He also held lodge, patriotic society and church membership.

Dr. John A. Van Kirk, Frankfort, is a brother, and Dr. John R. Van Kirk, Burlington, a son.

Edward H. Schlegel, M.D., 62, Fort Wayne, died shortly after suffering a heart attack in his home February 14.

Dr. Schlegel was a Fort Wayne native. After receiving his degree in medicine from Rush Medical College, Chicago, in 1917 and serving in the medical corps in France during World War I he returned to Fort Wayne where he had been in practice 36 years. Dr. Schlegel served on the board at Irene Byron Hospital for 25 years. He was a member of the Fort Wayne (Allen County) Medical Society, the Indiana State and American Medical Associations, and a diplomate of the International College of Surgeons.

Clifford M. Jones, M.D., 62, Whiting physician since 1924, died in his home in that city on February 16 of a heart condition he had suffered for seven years. He had been in practice during that period.

Dr. Jones was a native of Allen county. He received his degree in medicine from Indiana University School of Medicine in 1923 and the following year established his Whiting practice. He was a veteran of World War I.

Throughout his career he had been active in medical affairs, serving as a delegate to Indiana State Medical Association for a period of 10 years; as president of his own county society council; as a director of Parramore Hospital and a member of Whiting Board of Health. At the time of his death he was a member of the Grievance Committee of ISMA. He was a member of Lake County Medical Society, the Indiana State and American Medical Associations.

Edwin A. Lawrence, M.D., 45, professor of surgery and cancer research coordinator for Indiana University School of Medicine, died February 20 in Robert W. Long Hospital, Indianapolis, of cancer.

Dr. Lawrence was a recognized authority on cancer research and surgery. He began his career in that field while taking postgraduate work at Yale University following his graduation in 1935 from Western Reserve University School of Medicine. During those postgraduate years and his internship and residency at New Haven, Connecticut, Hospital, Dr. Lawrence headed the hospital's tumor clinic.

His teaching career took him from Yale University Medical School where he was an instructor in radiology and surgery, to the University of Utah in 1946 as assistant professor of surgery. He was professor of surgery there from 1948 to 1950 and established an outstanding cancer research and treatment center.

Dr. Lawrence came to Indiana University School of Medicine in 1950 and his five year

tenure there was marked by the progressive expansion of the cancer research program culminating in the opening two years ago of the Cancer Research Center, a $500,000 building for which Dr. Lawrence made original plans and supervised procurement of equipment.

A sincere advocate of postgraduate work for all practicing physicians, Dr. Lawrence established the annual Symposium on Malignancy at the Medical Center and also served as chairman of the Committee on Instructional Courses for the ISMA annual conventions on several occasions.

Dr. Lawrence was a prolific writer of articles and publications on cancer and surgery. He had allied himself with many medical organizations in the belief that the fight against cancer was one of universal urgency. He worked with the Indiana Cancer Society and with all civic groups which had helped raise funds for cancer research. He continued to promote the fight after his own illness had been diagnosed as cancer.

He was active in Indianapolis Medical Society, the Indiana State and American Medical Associations, the American College of Surgeons, Society of University Surgeons, American Board of Surgery, American Society for Thoracic Surgery and was a founder-member of the Board of Thoracic Surgery. He also belonged to the Central Surgical Association, and the American Association for Cancer Research.

Joseph Orth Thayer, M.D., 71, died February 22 in Robert W. Long Hospital, Indianapolis.

A native of Hamilton county, Dr. Thayer lived near Noblesville. Following graduation from Indiana University School of Medicine in 1917, Dr. Thayer served in the Army Medical Corps. He then returned to Indianapolis, took a residency at Methodist Hospital, and had been in general practice in the Indianapolis area since that time. He also worked for the Veterans Administration office and was insurance examiner for several companies. He was a member of Indiana State Medical Association for many years.

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General Surgery, Two Weeks, April 23
Thoracic Surgery, One Week, June 4
Esophageal Surgery, One Week, June 11
Breast & Thyroid Surgery, One Week, June 18
Gallbladder Surgery, Ten Hours, June 25
Fractures & Traumatic Surgery, Two Weeks, June 18
Varicose Veins, Ten Hours, April 30, June 18

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, April 16, June 18
Vaginal Approach to Pelvic Surgery, One Week, April 30, June 11

OBSTETRICS—General & Surgical Obstetrics, Two Weeks, May 7

MEDICINE—Internal Medicine, Two Weeks, May 7
Electrocardiography & Heart Disease, Two Weeks Basic Course, July 9
Gastroscopy & Gastroenterology, Two Weeks, September 10
Dermatology, Two Weeks, May 7

RADIOLOGY—Diagnostic X-Ray, Two Weeks, April 30, September 17
Clinical Uses of Radioisotopes, Two Weeks, May 7

PEDIATRICS—Intensive Review Course, Two Weeks, May 14
Neurological Diseases: Cerebral Palsy, Two Weeks, June 18

UROLOGY—Two-Week Course, October 8
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NEWS NOTES—from State and Nation

Dr. Paul D. Crimm to Return to Evansville

The board of managers of Boehne Hospital, Evansville, has announced the signing of a formal contract with Dr. Paul D. Crimm who will return to Boehne as superintendent and medical director on May 1. Dr. Crimm resigned the superintendency at the Evansville tuberculosis hospital in May, 1954 after a 25-year tenure. He had also served as medical and surgical chief during most of that time.

For the last two years, Dr. Crimm has been in private surgical practice with his brother, Dr. H. Eugene Crimm in Sidney, Ohio. Long hours of surgical work there resulted in the development of an allergy to latex rubber gloves, which was one of the determining factors in his return to Evansville. He will perform only incidental and emergency surgery after his return to Boehne.

Dr. Crimm fills a vacancy which has existed since December 7, 1955 when Dr. Joseph E. Moody, Crimm's successor, died. The hospital has been in charge of Dr. Donald E. Rayl, Evansville thoracic surgeon, who has served the hospital on a contractual basis since 1954. He is in private practice in Evansville.

The board's statement said: "The board regards this opportunity to re-engage Dr. Crimm to fill the vacant position of superintendent as fortuitous, both for the hospital and for the community."

Dr. Crimm served as president of Indiana State Medical Association in 1952-53.

Dr. Jeraldine C. Baumgartner, who had practiced in Fort Wayne for 15 years, began her new duties as a member of the medical staff of Smith College, Northhampton, Massachusetts, on February 1. Dr. Baumgartner is a native of Fort Wayne and received her degree in medicine from I. U. School of Medicine in 1939.

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The 32nd annual meeting and 29th annual scientific sessions of the **American Heart Association** will be held in Cincinnati, October 27-31. Those wishing to present either papers or scientific exhibits at the sessions must submit abstracts or make application to the Medical Director, American Heart Association, 44 East 23rd Street, New York 10, New York, no later than May 15.

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Three Indiana Physicians on Industrial Health Programs

Dr. L. W. Spolyar, director of the Division of Industrial Hygiene, Indiana State Board of Health, addressed an Industrial Health Clinic in Milwaukee on January 12. His topic was "Commonly Used Toxic Solvents." The meeting was sponsored by Industrial Health committees of the Milwaukee County Medical Society, Wisconsin State Board of Health, State Medical Society of Wisconsin and Wisconsin State Nurses Association.

On April 23 Dr. Emmett B. Lamb, Indianapolis, will speak on "Industrial Medical Directives" to the American Association of Industrial Nurses who will meet in conjunction with the 1956 Industrial Health Conference in Philadelphia, April 21-27.

Dr. Richard C. Swan, Anderson, will speak on "Selective Job Placement" before the same group on April 25.

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held in various places throughout the country on June 12, 13, 14 and 15. Appointments provide opportunities for career service in clinical medicine research and public health. They will be made in the ranks of Assistant and Senior Assistant, equivalent to Navy ranks of Lieutenant (j.g.) and Lieutenant.

Application forms may be obtained from the Chief, Division of Personnel, Public Health Service, Department of Health, Education and Welfare, Washington 25, D. C. Completed forms must be received by April 30, 1956.



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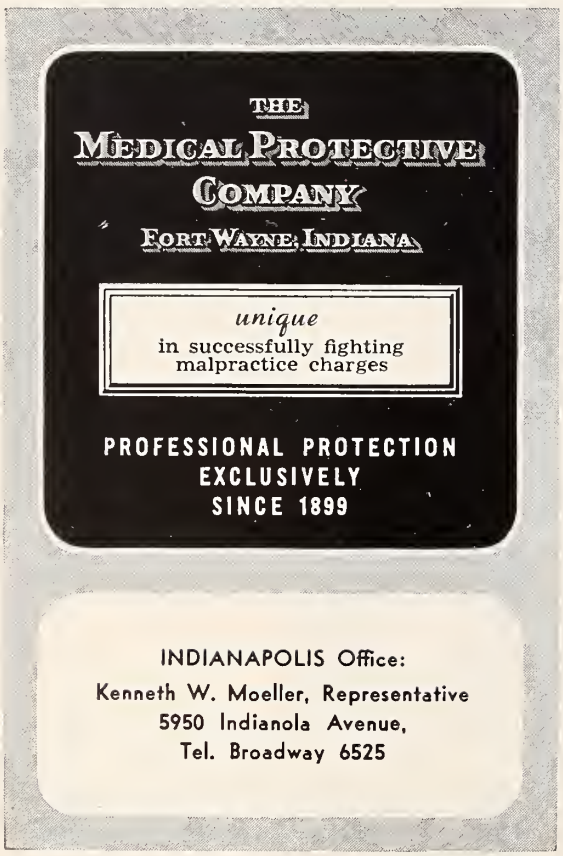
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Two recent additions to the staff of Norways Foundation Hospital, Indianapolis, have been announced. Dr. John E. Kooiker has been added to the attending staff, and Dr. John M. Albea to the staff of resident physicians. Dr. Kooiker was recently on the staff of Winter VA Hospital at Topeka. He was a resident physician from 1949 to 1952 in the Menninger Foundation School of Psychiatry. He is certified by the American Board of Psychiatry and Neurology. Dr. Kooiker's office for private practice is at 401 East 34th Street, Indianapolis. Dr. Albea is a graduate of Tulane University Medical School, interned at William Beaumont Army Hospital in El Paso, Texas, and has spent one year at Eastern State Hospital, Williamsburg, Virginia.



Cerebral Palsy Symposium Scheduled for April 18

The second annual Symposium on Cerebral Palsy will be held in the auditorium of Indiana University School of Medicine Wednesday, April 18 from 3:30 to 5:30 p.m.

This symposium has been arranged to give an opportunity for a neuropathologist, obstetrician, neurologist, neurosurgeon, pediatrician, and orthopedist to discuss briefly and in a general way the known facts regarding the etiology, diagnosis, treatment and end result evaluation of children with cerebral palsy.

The program follows:

1. Pathologic Findings in Cerebral Palsy----------
 Dr. Orville T. Bailey,
 Professor of Neuropathology
2. Obsterical Factors in Cerebral Palsy---------
 Dr. Carl P. Huber,
 Chairman and Professor of Obstetrics and Gynecology
3. Neurological Examination in Cerebral Palsy--
 Dr. Louis Nie,
 Assistant Professor of Psychiatry and Neurology
4. Surgical Aids to the Cerebral Palsied--------
 Dr. Robert Heimburger,
 Assistant Professor of Surgery and,
 Chief, Division of Neurosurgery
5. Pediatric Recognition and Care of the
 Cerebral Palsied Child----Dr. Jane Brownley,
 Assistant in Pediatrics
6. Orthopedic Management of the Cerebral
 Palsied Patient --------Dr. Edward Schaffer,
 Assistant in Orthopedic Surgery, and
 Dr. Carl D. Martz
 Associate Professor of Orthopedic Surgery

Dr. Harry G. Hockett, director of professional services at the Veterans Administration Hospital in Marion, has been appointed manager of the hospital which has 1,650 beds for neuropsychiatric patients. He succeeds Dr. Arvin E. Trollinger who was transferred to the VA hospital in Lyons, New Jersey.

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Lake County Medical Society will act as host to the Industrial Physicians and Surgeons convention on May 25 at the Hotel Gary. This will be a joint meeting with the Tenth District Medical Society. A tour of the U. S. Steel Corporation plant has been planned as part of the one-day session, an announcement by John B. Twyman, executive secretary, reports.

The 22nd annual meeting of the *American College of Chest Physicians* will be held in the Hotel Sherman, Chicago, June 6-10. The scientific program will include prominent speakers on all aspects of heart and lung diseases.

Examinations for Fellowship in the College will be held on June 7, and more than 150 physicians will receive their certificates at the annual convocation, June 9.

All interested physicians are invited to attend. There is no registration fee. Copies of the program may be obtained by writing to the Executive Offices, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Indiana Trudeau Society to Meet in Indianapolis April 25

The annual meeting of the Indiana Trudeau Society (the medical branch of the Indiana Tuberculosis Association) will be held on April 25 at the Hotel Sheraton-Lincoln, Indianapolis.

The program will begin at 2 p.m. with Dr. Donald W. Brodie, Indianapolis, president of the society, presiding.

H. S. Willis, M.D., Chapel Hill, North Carolina, President of the American Trudeau Society, will speak on "Prolonged Therapy," and Warren S. Tucker, M.D., Indianapolis, will have as his subject, "The Use of Antibiotics in Home Treatment."

A panel discussion on Follow-up Policy will close the meeting. The panel members will be, Philip H. Becker, M.D., Crown Point; H. G. Nester, M.D., David F. Stone, M.D., and Warren S. Tucker, M.D., all of Indianapolis.

At a joint session with the Indiana Tuberculosis Association on Wednesday morning, Dr. Willis is scheduled to speak on "The Changing Picture in Tuberculosis Control."

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*Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, ed. 3, Baltimore, The Williams and Wilkins Company, 1954, p. 998.

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Bloomington Doctor Honored For Safe, Courteous Driving

Because Dr. Herman S. Hepner, Bloomington physician, was the first driver in a long stream of traffic to stop his car to permit a large truck to make a left turn into the busy street and because in his 43 years of driving an automobile he has never had a major damage wreck, the Bloomington Police Department selected him as the "Driver of the Month" for February. His act of courtesy was witnessed by Police Capt. Charles Fox who said "I thought that was an outstanding display of courtesy. None of the other drivers who had gone by would let the driver through."

Dr. Hepner believes one should "never hurry". Explaining he said, "You can hurry at 30 miles an hour just the same as you can at 70. It's a mental condition. I always let the other fellow have the right of way, wherever he is. Some time I might be in that same predicament myself."

Dr. Peter Petrich has been named to the Attica Board of Health for a term ending December 31, 1959. Appointment was made by the City Council February 27.

The special **convention review edition** of the Bulletin of the National Society for Crippled Children carried the following news concerning Indiana residents: Dr. R. L. Sensenich, South Bend, served on the 5-man nominating committee to select national officers for 1956; C. Walter McCarty, editor of the Indianapolis News, was a member of a panel which discussed "Conquering Crippling—Whose Responsibility?" (Dr. Morris Fishbein was also a member of the panel); Roy Patton of Crossroads, Indianapolis, is president of the Easter Seal Executives Association: James J. Nance, president of the Studebaker-Packard Corporation of Detroit and South Bend was named a member of the governing board, the 18 trustees-at-large. In addition an illustrated feature on the laying of the cornerstone for the new Crossroads Rehabilitation Center in Indianapolis was published. One photograph shows the actual laying of the cornerstone by William R. Krafft, chairman of the building campaign, assisted by Dr. William H. Norman, 1955 president of Indianapolis Medical Society, and Linda Langenbacher, a 4 year old crippled child.

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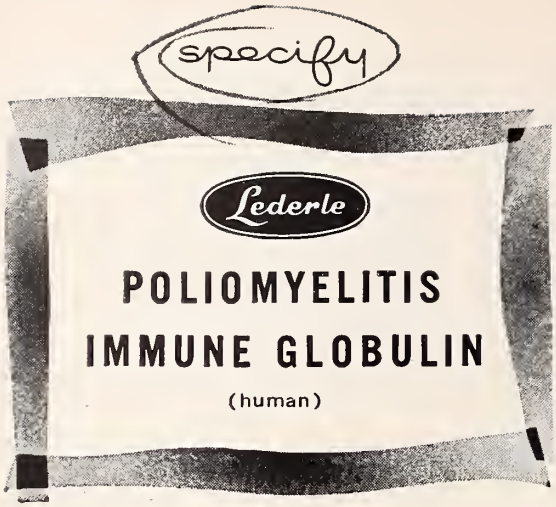
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Camp for Diabetic Children Starts Second Season June 17

This summer the Indianapolis Diabetes Association, Inc. will again operate the James Whitcomb Riley Camp for diabetic children. Encouraged by a most successful opening season last year, this group is now formulating plans for the second season from June 17, 1956 to July 14, 1956. The camp is located in the Bradford Woods Outdoor Education Area six miles north of Martinsville. This is a permanent, solidly constructed facility featuring a spacious dining and recreation hall, modern infirmary, and tent cabins. Diabetic boys and girls, ages 8 to 16, are eligible on a non-sectarian basis.

A resident physician and one or more registered nurses, trained in the care of diabetic children, will be in attendance at all times along with a full time dietitian and medical technician. Daily visits are made by physician members of the Indianapolis Diabetes Association, Inc. to supervise the professional staff and the excellently equipped laboratory. Herbert Montgomery of New Castle, well known as an outstanding counselor, will again direct camping activities of the children.

Campers will be accepted only for the full four weeks since the child will not obtain the maximum benefit from a shorter period. The fee for the four weeks is $200.00 and is all inclusive. Limited funds may again be available to modify the fees in selected cases. Capacity is limited to 40 and requires prompt application. Applications may be obtained from, and inquiries addressed to: Mrs. Leanah K. McNeely, Secretary, Indianapolis Diabetes Association, Inc. Society of Lay Members, 68 Kenmore Road, Indianapolis, Indiana.

Next scheduled examinations (Part II) oral and clinical for all candidates for certification by the **American Board of Obstetrics and Gynecology** will be conducted at the Edgewater Beach Hotel, Chicago, by the entire Board from May 11 through May 20. Formal notice of the exact time of each candidate's examination will be sent him in advance. Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations.



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References: 1. Bunim, J. J., et al.: J.A.M.A. 157:311, 1955. 2. Forsham, P. H., et al.: Paper presented at First Internat. Conf. on Prednisone and Prednisolone, New York, May 31-June 1, 1955. 3. Perlman, P. L., and Tolksdorf, S.: Scientific Exhibit presented at A.M.A. Annual Meet., Atlantic City, June 6-11, 1955.

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Aero Medical Association Meets April 16-18 in Chicago

The annual meeting of the Aero Medical Association will be held in the Drake Hotel, Chicago, on April 16, 17, and 18. This year's meeting will provide the most comprehensive review of current progress in aviation medicine ever presented. All members of the profession are invited to attend any or all of the session.

The Wives Wing of the Aero Medical Association composed of more than 300 wives of association members will hold their annual functions on the same dates. All wives of physicians are cordially invited to attend.

On April 26-28 the **International College of Surgeons** will hold a regional meeting of its American section in Madison, Wisconsin, with headquarters at the Loraine Hotel. This will be a midwest meeting with all surgeons residing in this area invited to attend. Leading surgeons from throughout the United States will appear on the program. Announcement was made by Dr. Arnold S. Jackson, president of the United States Section.

Dr. A. N. Ferguson, Fort Wayne, was guest speaker at the February meeting of the Northeastern Indiana Dietetic Association held in the nurses residence at St. Joseph Hospital, Fort Wayne. He spoke on "Latest Developments in Heart Disease in Relation to Diet."

North Vernon Physician Honored by Civic Club

Dr. John H. Green, who has served the North Vernon community as physician for 45 years, was honored recently when members of the Business and Professional Women's Club in North Vernon presented an isolation crib to the Schneck Memorial Hospital in Seymour. The presentation was made in tribute to Dr. Green who during his career has delivered 3,138 babies, many of them in the Seymour hospital.

Dr. Charles G. Matheus has been named a member of the Union City health board, succeeding Dr. H. C. Rothermel, Dr. B. D. Wagoner is also a member of the board.



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Annual pediatric postgraduate course presented by the Department of Pediatrics, University of Louisville, in conjunction with the Kentucky State Medical Association and the Kentucky Child Health Foundation will begin May 1 and continue each Tuesday morning through June 19. Sessions will be held in Children's Hospital, Louisville. There is a small registration fee. Credit for the course will be given by the AAGP. Inquiries may be directed to The Department of Pediatrics, 323 East Chestnut Street, Louisville 2, Kentucky.

Medical School Faculties Aided by Markle Fund Grants

The John and Mary R. Markle Foundation announced recently the appointment of 23 Scholars in Medical Science, all faculty members of medical schools in the United States and Canada. The fund appropriated $690,000 toward the support of these doctors and their research, to be granted at the rate of $6,000 annually for five years to the 23 medical schools where they will teach and carry on research.

One of the awards went to the University of Florida College of Medicine for Charles F. Crampton, Ph.D., who received his degree in biochemistry from Indiana University. He is now with the Rockefeller Institute for Medical Research but will assume his post in Florida July 1. He will serve as assistant professor of pathology and assistant professor of biochemistry.

Last 3 PG Programs on Radioisotopes Announced

The concluding three sessions of a Clinical Course in Radioisotopes will be presented at Indiana University School of Medicine on April 18, April 25, and May 2. The programs will be held between 1 and 6 p.m.

APRIL 18

1. Treatment of Polycythemia Vera with P32____ Indiana University Staff
2. Chronic Leukemia and Lymphoma Treated with P 32 _____Indiana University Staff
3. Beta Radiation of Ophthalmic Lesions with Strontium-90 _____Dr. Fred Wilson, I.U.
4. Teleotherapy with Cobalt-60 and Other Gamma Emitters _Dr. James Carpender, Chicago

APRIL 25

1. Treatment of Malignant Effusions with Radioisotopes _____Dr. H. B. Elkins, Iowa City
2. Interstitial Therapy of the Prostate and Other Lesions with Radioactive Gold_____ Dr. Elkins
3. Interstitial Therapy with Cobalt-60 and Other Gamma Emitters _____ Dr. Joseph Morton, Indianapolis
4. Other Therapeutic Uses of Radioactive Gold _____Indiana University Staff

MAY 2

1. Radiation Genetics _____Dr. Herman Mueller, Bloomington
2. Other Diagnostic and Therapeutic Uses of Radioisotopes _____Dr. Donald Tabern, Chicago

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Homatropine Methylbromide	2.5 mg.

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American Goiter Association Meeting in Chicago May 3-5

Members of the Indiana State Medical Association are invited to attend the meeting of the American Goiter Association which will be held in Chicago on May 3, 4 and 5, at the Drake Hotel. The program will include presentations on all aspects of thyroid disease both medical and surgical, and of thyroid physiology.

Gary Surgeon Listed on 25-Man All-America 'Team'

Dr. Joseph C. Donchess, chief surgeon of the Gary Steel Works, was one of 25 physicians listed on a mythical football team in a special feature in Spectrum, a medical supplement in the Journal of the American Medical Association. The Spectrum is released by Pfizer Laboratories.

All doctor-members of the football team are former All-American selections.

Dr. Donchess was an end on the University of Pittsburgh eleven when he was named All-American in 1929.

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Dr. Ladislas D. Wojcik, pediatrician with the Davis Clinic at Marion, has been certified as a diplomate of the American Board of Pediatrics. Dr. Wojcik is a graduate of Harvard Medical School in Boston. She has headed the Salk vaccine program in Grant county.

Lilly Steps Up Polio Vaccine Production

Eli Lilly and Company announces that it is greatly increasing the harvesting and testing of polio vaccine in an effort to make available an extra 20,000,000 doses by June 30.

Lilly says that harvesting is being stepped up 50 percent to a production rate of 6,800,000 cc. a month.

The company hopes to submit a total of 60,000,000 cc. to the National Institutes of Health during the first six months of this year. Originally the company's goal was 40,000,000 cc. by June 30.

To reach the 60,000,000 total, Lilly is enlarging its testing activities to process a large backlog of vaccine which has been harvested but not tested.

A summer camp for diabetic children will be operated under the auspices of the Chicago Diabetes Association, Inc., at Holiday Home, Lake Geneva, Wisconsin from July 15 to August 5. The camp will be fully staffed. This will be the eighth season. Boys and girls, 8 through 14, are eligible. Fees are set on a sliding scale. Inquiries should be addressed to: The Chicago Diabetes Association, Inc., 5 South Wabash Avenue, Chicago 3, Illinois.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

February 22, 1956

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; W. U. Kennedy, M.D.; Elton R. Clarke, M.D.; Kenneth L. Olson, M.D.; O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

Membership Report

Number of members February 22, 1956	3,214*
Number of members February 22, 1955	3,125
Gain over last year	89
Number of members December 31, 1955	3,971

* Includes
79 in military service (gratis)
61—$10.00 members (residents and interns)
251—senior members
51—members, dues remitted by Council

Number who have paid AMA dues:

February, 1956	2,615
February, 1955	2,164
Gain	451

Treasurer's Office

The treasurer discussed the recent action of the House of Delegates in establishing a student loan fund, and on motion of Drs. Clarke and Olson it was ordered that this be established as a separate account, the details and choice of depository to be left to the treasurer.

Statements of Receipts and Expenditures for January for the Association and THE JOURNAL were approved.

Headquarters Office

The field secretaries reported on their activities during the past month.

The committee reviewed the trust indenture for the retirement fund and upon motion of Drs. Sicks and Olson the indenture was accepted as amended, subject to the approval of the trustees.

Upon motion of Drs. Clauser and Clarke the following were named as trustees for the retirement fund:

Chairman of the Council
Chairman of the Executive Committee
Treasurer of the Association

Legislative Matters

National The annual trip to Washington in conjunction with the Chamber of Commerce, scheduled for May 1, 1956, was discussed, and on motion of Drs. Olson and Clauser, the president, president-elect and co-chairmen of the Legislative Committee are to be asked to attend.

Organization Matters

The requests of the Lake County, St. Joseph County, Bartholomew-Brown County Medical Societies for remission of dues of one member in each of these societies were approved on motion of Drs. Clarke and Clauser.

Letter from C. E. Pauley & Co., Inc., printers of THE JOURNAL, was read in which the Association was notified of an increase in rates for printing THE JOURNAL, effective with the February issue.

Statement for $10.00 for membership dues in the Indiana State Conference on Social Work was approved and ordered paid on motion of Drs. Olson and Clauser.

Dr. A. C. Offutt, secretary of the State Board of Health, appeared before the committee and explained the distribution of polio vaccine and supplied the committee with a report showing the distribution throughout the State of Indiana.

The secretary informed the committee of the notice given to some Indiana hospitals by the United Mine Workers in which they requested the hospital to meet accreditation standards as a basis for being eligible to handle cases being paid for by the United Mine Workers Fund. Also reported was the conversation with the Joint Commission on Accreditation of Hospitals and the regional office of the United Mine Workers Health and Welfare Fund.

The Journal

Report on advertising was approved by consent:

Total advertising, February, 1956	$3,241.73
Total advertising, February, 1955	2,786.06
Net gain	$ 455.67

The editor of THE JOURNAL asked the committee for its opinion on naming the April issue of THE JOURNAL, the annual cancer issue, "The Ed Lawrence Memorial Issue." Upon motion of Drs. Clauser and Clarke the editor was authorized to so name the issue in memory of Dr. Lawrence whose accomplishments in the field of cancer research they felt was outstanding.

There being no further business the committee adjourned to meet again at 2:30 p.m., Wednesday, March 14, 1956, in the Student Union Building, I. U. Medical Center, Indianapolis.

News from the County Societies

Dr. Kenneth B. Babcock, Director of the Joint Commission on Accreditation of Hospitals, spoke to an audience of 108 members and guests of **Fort Wayne (Allen County) Medical Society** at a dinner meeting February 7. The meeting was held in the Chamber of Commerce, Fort Wayne, with the boards and key personnel of the three Fort Wayne hospitals as special guests.

At the March 6 meeting of the Fort Wayne society Dr. Carl P. Huber, professor of obstetrics and gynecology at I. U. School of Medicine, was the speaker. He presented a paper on "Uterine Bleeding" before 86 members of the society. This was also a dinner meeting in the Chamber of Commerce. Arrangements for the scientific program were made by Drs. Mahlon Miller and Robert Wilkins.

Bartholomew-Brown County Medical Society met February 8 in Palm's Cafe, Columbus, for a dinner and a program featuring two guest speakers, Allen A. Golter, attorney, and L. E. Converse, director of public relations for Blue Shield. Mr. Golter discussed "Malpractice and Medical Jurisprudence" and Mr. Converse discussed the status of Blue Shield and demands of industry for a comprehensive hospitalization insurance plan. A question and answer period followed. Twenty-one members were present.

Boone County Medical Society members held an evening meeting February 7 in Witham Memorial Hospital, Lebanon, to hear a discussion of the Red Cross Blood Bank program, Ned C. Boatright and Herman Antle spoke. Eleven members attended the meeting.

The society held a business meeting in the Lebanon hospital on March 6 with 13 members present.

Discussion and formulation of plans for the district medical meeting in May highlighted the February 15 meeting of the **Carroll County Medical Society.** Thirteen members attended the dinner meeting in the American Legion home, Delphi.

Twenty-five members of **Cass County Medical Society** met jointly with the Woman's Auxiliary on February 20 in the home of Dr. Paul H. Wilson, Logansport. At a brief business meeting the proposed government plan for care of military dependents was discussed.

At a dinner meeting of the **Crawford-Harrison County Medical Society,** March 1, the 10 members present discussed the new hospital wing for the Harrison County Hospital, Corydon, which will double the capacity of the hospital. The meeting was held in the hospital and members learned that the contract for construction had been let.

Robert J. Amick, ISMA field secretary, reported on activity in Washington, the County Medical Officers Conference, and a general discussion of many subjects of local interest followed.

Eleven members of **Daviess-Martin County Medical Society** met at the Daviess County Hospital, Washington, March 5, for a hospital staff meeting after which the society heard R. J. Amick, ISMA field secretary, discuss the Science Fairs program for students, action pending in Congress, and other matters of interest to the profession.

A breakfast meeting of the **Decatur County Medical Society** was held in the Decatur County Hospital, Greensburg, February 22, with 10 members present.

Dr. Robert Porter gave a review of the cases of two of his chest patients.

Following the regular business meeting, the ISMA field secretary spoke briefly on the public relations poll taken under the direction of A.M.A. on a national scale; of important bills now before Congress and issued an invitation to all members to attend the County Medical Society Officers Conference in Indianapolis March 18.

Twenty-eight members of the **Dubois County Medical Society** and the Woman's Auxiliary met February 9 in the Jasper Country Club for dinner and separate business meetings.

At the society meeting there was general discussion of the polio vaccination program followed by a report of activities at state and national levels by the ISMA field secretary.

Delaware-Blackford County Medical Society members held a dinner meeting January 17 in the Delaware Hotel in Muncie with 50 physicians present. Dr. E. H. Clauser and Dr. Guy Owsley gave detailed reports on the winter meeting of the Council.

Kenneth W. Bush, ISMA field secretary, reported on the status of H. R. 7225, the survey on social security sentiment, and medical defense services.

The society voted to send a letter to the Indiana Senators expressing a majority opinion of the society on such matters as the Bricker Amendment, foreign aid program, and H. R. 7225. Individual physicians were urged to express their opinions directly.

Dr. H. Glenn Gardiner, director of the medical department of Inland Steel Company, East Chicago, and the head of the occupational hygiene division of the medical department, were guest speakers at the February 2 meeting of **Elkhart County Medical Society** in the Robert Gair Co., Inc., American Coating Mills Division plant in Elkhart. Dinner was served at John Bevan's Steak House prior to the 8 o'clock meeting in the plant.

Dr. Gardiner and Mr. McCormick spoke on "The Preventive Medical Aspect of an Occupational Health Program in the Steel Industry".

After the program there were conducted tours through the enormous plant for the 50 members who attended.

Thirteen members of the **Fayette-Franklin County Medical Society** attended a dinner meeting in the Connersville Country Club on February 14. Dr. Walter U. Kennedy, president of Indiana State Medical Association, was a special guest and spoke informally on the Science Fairs and bills proposing medical care for military dependents.

A film on "Hydrocortisone" was shown by Ray Taylor, Upjohn representative, who discussed the uses of the drug.

Dr. Ephraim Roseman, Louisville neurologist, presented a paper on "Epilepsy" at the March 9 meeting of the **Floyd County Medical So-**

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ciety in the New Albany Country Club. Twenty-seven members attended the dinner meeting.

A routine business meeting and brief report by R. J. Amick, field secretary, concluded the meeting.

Dr. T. T. Suzuki, president of the **Fountain-Warren County Medical Society,** entertained members and their wives at a buffet supper in his home in Covington March 1. Special guests were Dr. and Mrs. Paul Fishkorn of the DuPont Company, and Kenneth W. Bush, ISMA field secretary.

Dr. Harold W. Keschner, pathologist at St. Elizabeth's Hospital, Danville, Illinois, was the guest speaker. He presented a clinical pathological conference, illustrated with slides.

At a business meeting a resolution was adopted condemning H. R. 7225. Copies of the resolution were to be sent to Senators Capehart and Jenner, and to Representative Cecil M. Harden.

Ten members and six guests of **Gibson County Medical Society** met in the Emerson Hotel, Princeton, February 8, for dinner and a program. Dr. Milton Anderson, Evansville State Hospital, was the guest speaker. He presented a paper on the "Use of New Drugs in Emotionally Disturbed Patients".

Members discussed the establishing of an average fee schedule at their business meeting.

Members of the **Greene County Medical Society** heard a presentation of model constitution and by-laws to conform to requirements of the accrediting committee for hospitals at their meeting February 16 in Freeman Greene County Hospital, Linton. Speakers were J. B. H. Martin and Thomas Kinnane. Fourteen members attended the evening meeting.

"Diabetic Acidosis" was the title of the paper presented by Dr. Glenn Irwin, associate professor of medicine, Indiana University Medical Center, to members of **Henry County Medical Society,** February 16. The meeting was held at 8:30 p.m. in the Henry County Hospital, New Castle, with 20 members attending.



Dr. Charles N. Pease, center top, was guest speaker at a November meeting of Howard County physicians at the Frances Hotel, Kokomo. He is chief of orthopedics at Children's Memorial Hospital, Chicago. To his left is Dr. Lee M. Cattell, Jr., Kokomo; and to his right, Dr. Elton R. Clarke, Kokomo, president-elect of ISMA.

Dr. Marvin Golper, 1955 secretary, and Dr. Richard W. Halfast, 1955 president of Howard County Medical Society, are shown in lower photo.

Howard County Medical Society members held a business meeting at 5 p.m. February 8 in the Hotel Frances, Kokomo, with 18 members present, and then joined other doctors from that area of the state for dinner and the evening program of the Road Show presented by the Indiana Academy of General Practice. The Indiana Cancer Society and the Indiana Heart Association were co-sponsors of the Road Show.

Following dinner, Dr. Edward B. Smith, chairman and professor of the Department of Pathology at I. U. School of Medicine, and Dr. Robert J. Rohn, acting cancer coordinator and associate professor of medicine at I. U. School of Medicine, presented papers on "The Lymphomas".

Dr. Samuel H. Leuscher, biochemist in research at the Argonne Research Laboratory, University of Chicago, was the speaker at the February 16 meeting of the **LaPorte County Medi-**

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cal Society in the Hotel Rumely, LaPorte. He spoke on "The Effect of Irradiation by Radioactive Materials" and the members were particularly interested in his remarks on diagnosis and therapeutic effect by radioactive elements.

The meeting was devoted entirely to the scientific program. Attendance was reduced to 19 because of hazardous driving conditions.

At a noon meeting February 1 in Dunn Memorial Hospital, Bedford, 21 members of **Lawrence County Medical Society** heard Steve Geabes speak on the "Internal Security Corps". A business meeting followed. Members voted to give $200 to the Chamber of Commerce for the Business Education course.

Twenty-three members of the society attended the March 7 meeting, also held in the Bedford hospital. A Blue Cross representative gave a resume of the activity during the last year and plans for the future.

R. J. Amick, ISMA field representative, reported briefly on legislative and health programs. A film presentation by a Sharp and Dohme representative was shown at the conclusion of the business meeting.

Dr. Maurice M. Best, assistant professor of medicine at the University of Louisville, spoke on "Recent Trends in Diagnosis and Treatment of Atherosclerosis" at the February 14 meeting of **Indianapolis (Marion County) Medical Society** in the White Cross Guild Auditorium at Methodist Hospital.

Five new members were elected. They were Drs. Robert Flanders, Gordon T. Brown, Robert M. Palmer, Vincent B. Alig, and John D. Ralston, who transferred from Hamilton County.

Dr. Ralph V. Everly presided and introduced the guest speaker. A report of the February 7 Council meeting was given by Dr. Edward F. Bloemker.

Seven members of **Orange County Medical Society** held a dinner meeting in Spring Mill Park Inn March 6 with Dr. Marion Beard of

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Noble County Medical Society members are shown at right at a December 15 meeting in Kendallville. In upper photographs: Drs. Q. F. Stultz, Ligonier; Thomas Slough (new member); P. L. Webster, Ligonier; H. O. Williams, and C. B. Goodwin (1955 Physician of the Year), Kendallville; B. H. Pulskamp, Wolcottville; C. E. Munk, Kendallville; and J. R. Nash, Albion. Below are: Drs. E. D. Mattmiller and K. D. Sneary, Avilla; F. W. Messer and I. H. Lawson, Kendallville; A. L. Fipp, Rome City; C. F. Stallman, Kendallville; and C. M. Bowman, Albion.

the Louisville Red Cross Blood Bank as the guest speaker. He gave a paper on "Blood Transfusions" which stimulated a long discussion period. R. J. Amick, ISMA field secretary, discussed several matters with the members, including the polio vaccine program, Science Fairs, pending legislation, and the physician placement service of the State Association.

The **Owen-Monroe County Medical Society** met in the Bloomington Country Club February 23 for a dinner meeting with 29 members present.

During a business session which followed the society took action on several legislative matters, voted to sponsor the regional Science Fair in Bloomington and heard a report from the ISMA field secretary.

Dr. James Bopp, Terre Haute, presented a paper on "Spinals" at a February 15 meeting of the **Parke-Vermillion County Medical Society.** Thirteen members attended the dinner and program in the Vermillion County Hospital, Clinton.

At the business meeting which followed a summary of the results of an A.M.A. public opinion poll was given by the field secretary who also discussed current legislation and the Science Fairs project.

The **Porter County Medical Society** met February 28 in Porter Memorial Hospital, Valparaiso, with the 20 doctors holding a staff meeting first and the society meeting later.

The society resolved to send a letter to their senators and representatives outlining their position regarding H. R. 7225. Kenneth W. Bush, ISMA field secretary, reported on the current status of the bill.

The society also voted to drop attempts to set up a fee schedule as recommended by the I.S.M.A. House of Delegates.

Two tape recordings from the ISMA library were played as part of the program for the **Putnam County Medical Society** meeting February 10 in the DePauw Student Union building, Greencastle. The recordings were on "Gastric Ulcer Criteria for Determining Method of Treatment" by Dr. H. J. Kullman, and "Convulsive Seizures in Infancy and Childhood" by Dr. J. G. Hughes. The program was presented by R. J. Amick, field secretary, who also led a

discussion on the rural health program, public relations, and several bills up for passage by Congress.

Thirteen members attended the dinner meeting.

A noon luncheon meeting of **Spencer County Medical Society** was held February 28 in Cotton's Restaurant, Rockport, with three members and Robert J. Amick, ISMA field secretary, present. Mr. Amick reported on several subjects of interest to the medical profession and outlined services available from the headquarters office of ISMA.

Vanderburgh County Medical Society members joined with the First District Indiana Academy of General Practice on February 16 for a Road Show meeting in Hotel McCurdy, Evansville. A business session of the society was held following the scientific program. Dr. Robert Ziss was voted membership. He is an Evansville native and transferred his membership from the Chicago Medical Society.

Speakers at the scientific sessions were Dr. James King and Dr. Walter Moore of St. Louis University. Approximately 60 physicians were in attendance during the afternoon and evening programs.

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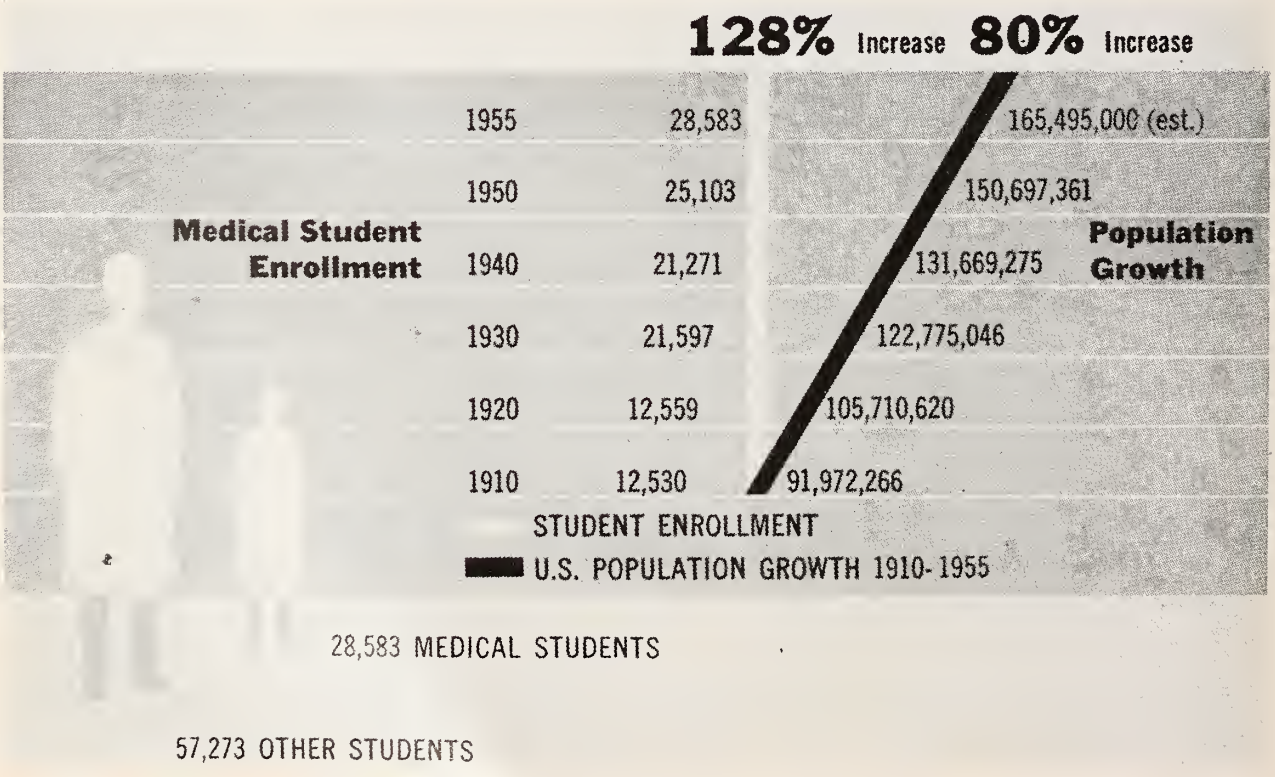
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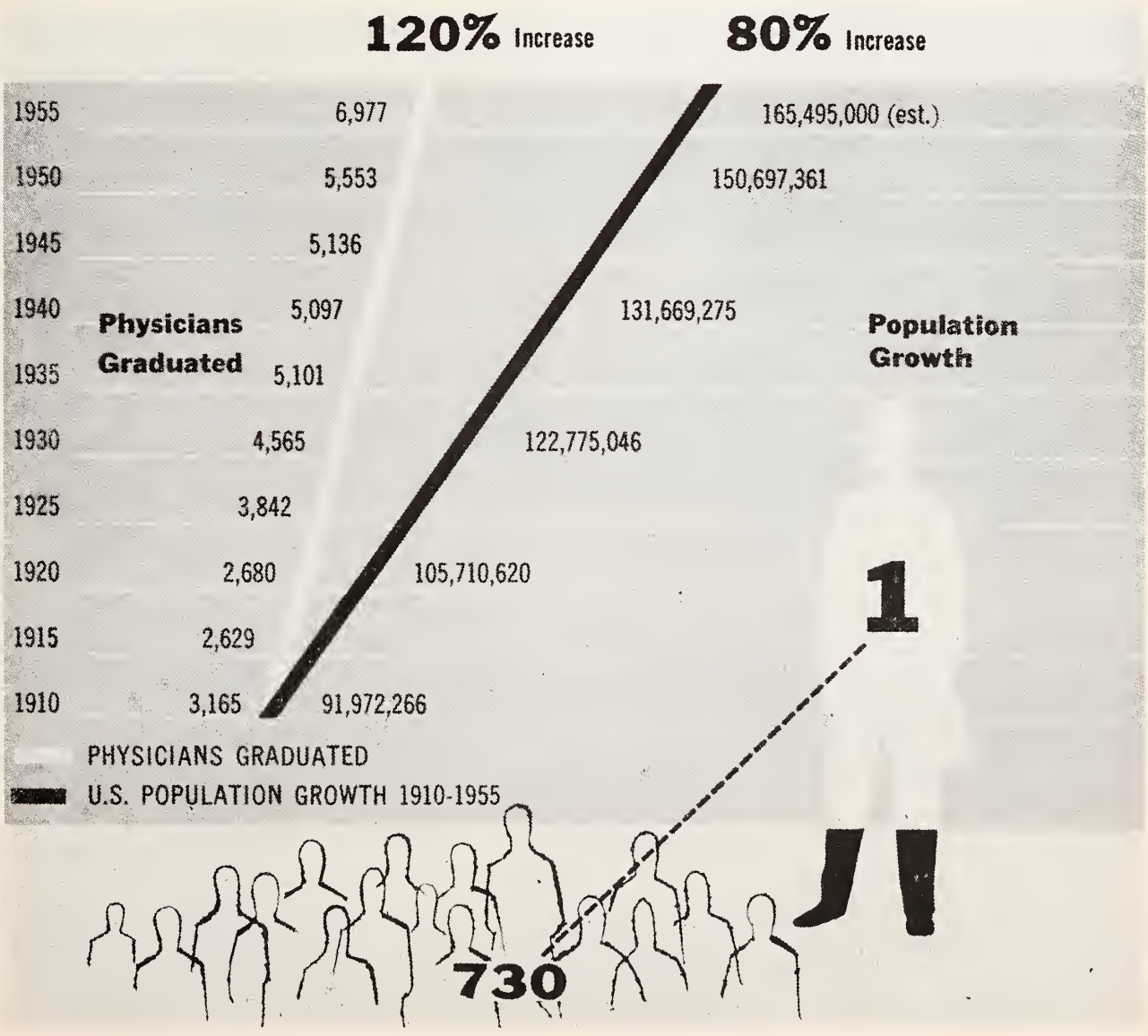
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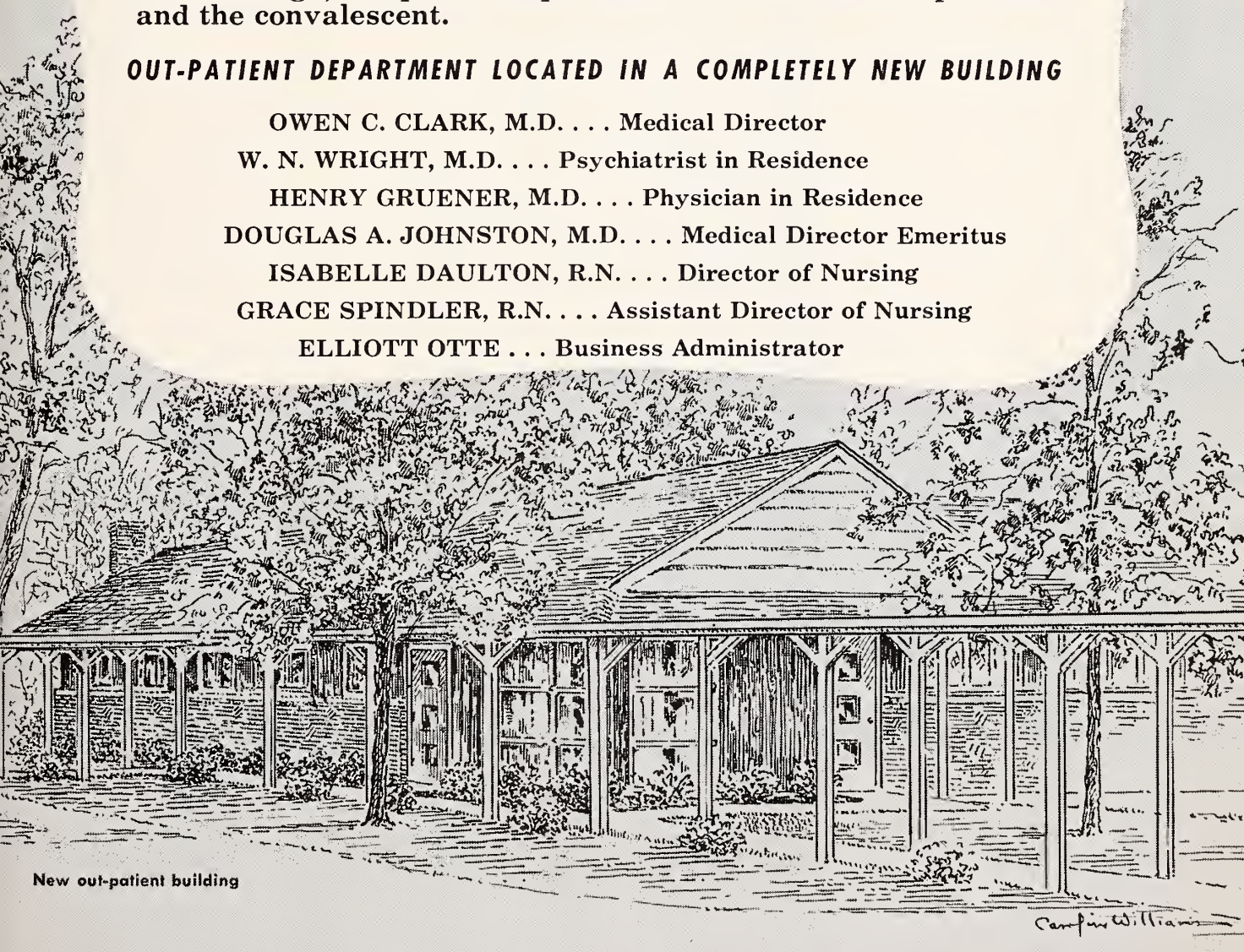
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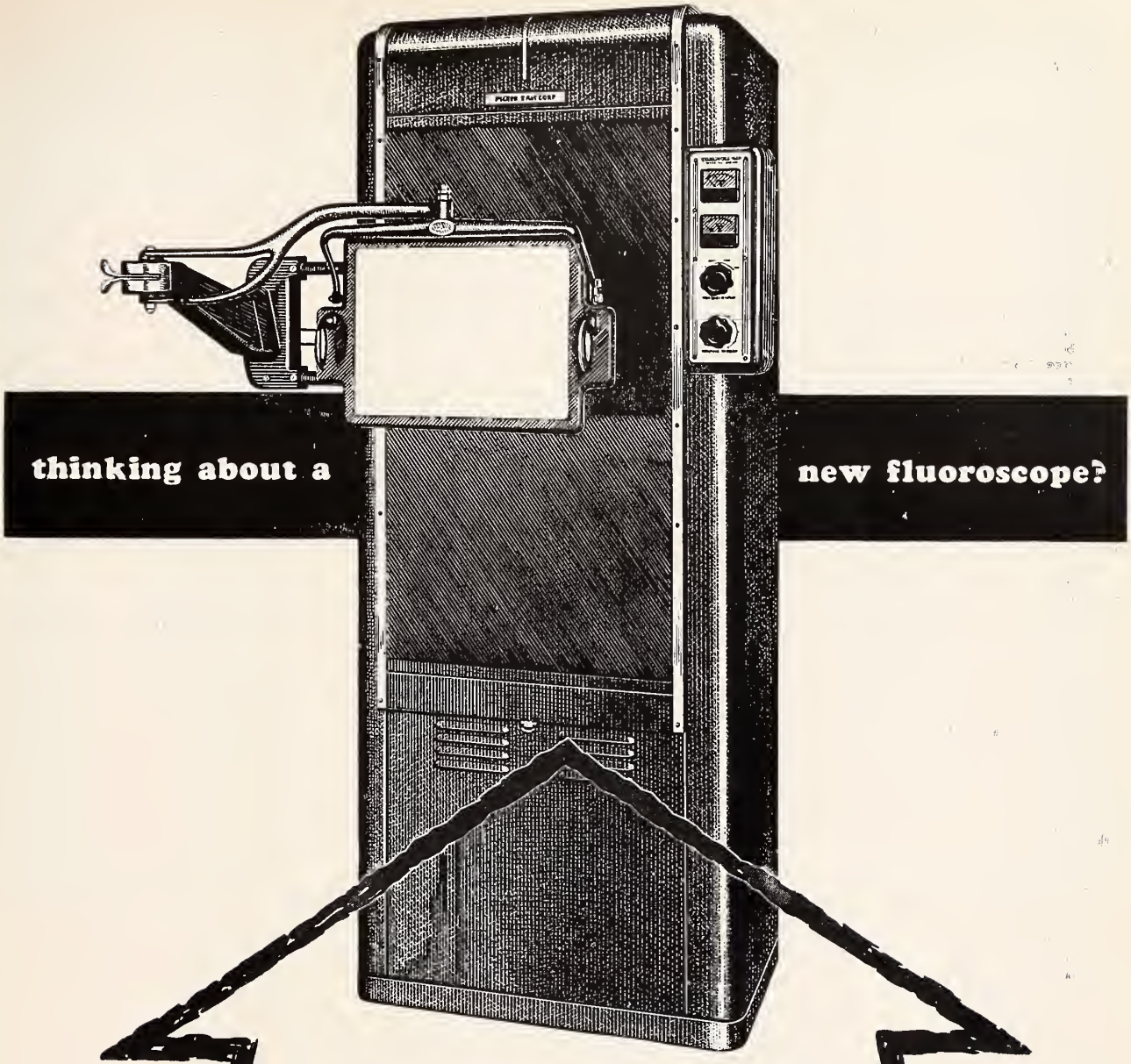
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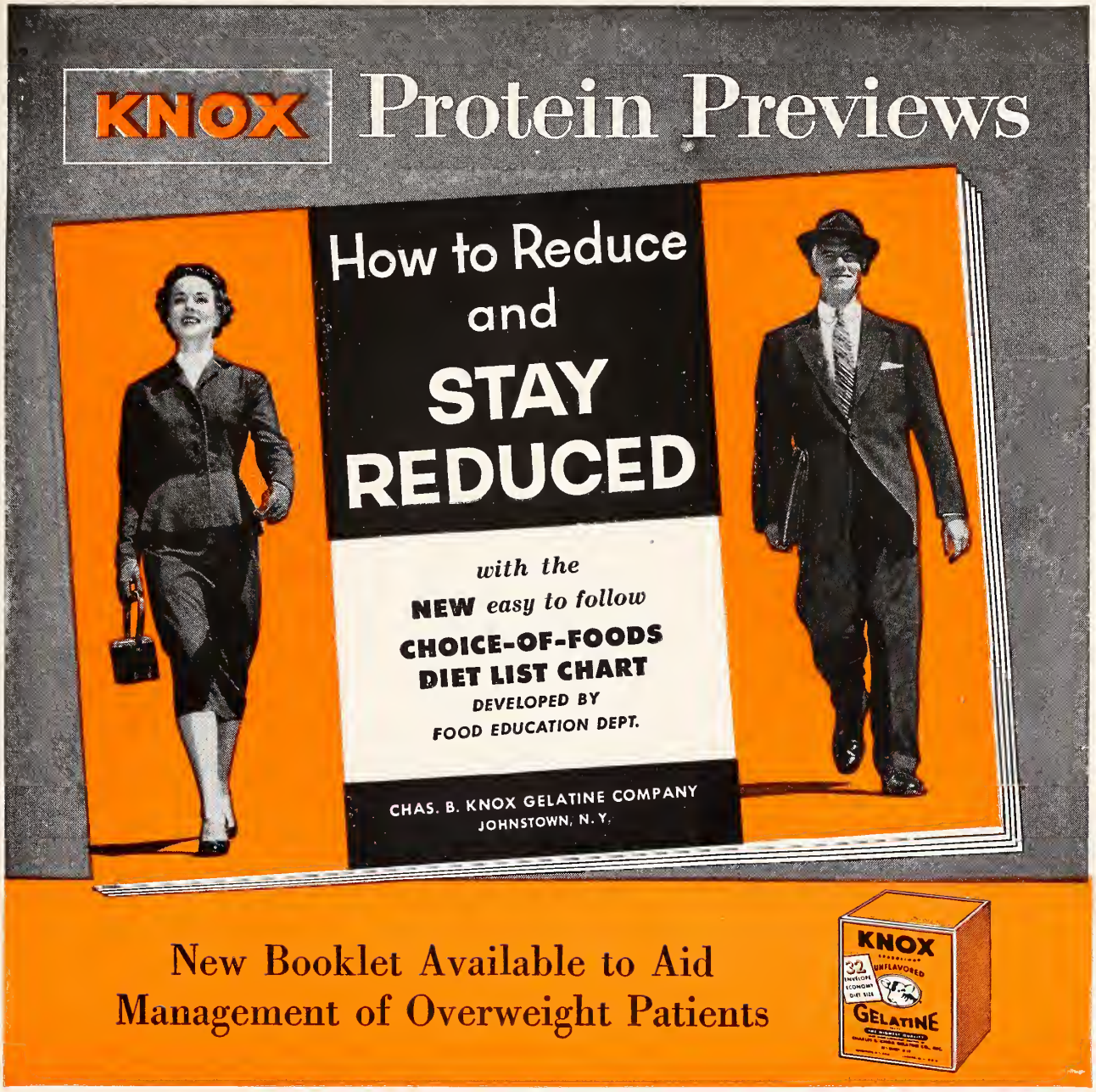
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To help patients persevere in their reducing plans, the last 14 pages of the new Knox booklet are devoted to more than six dozen *tested*, low-calorie recipes. Please use the coupon below to obtain copies of the new "Eat-and-Reduce" booklet for your practice.

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The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

PICKETS PRESSURE DOCTORS IN COAST BUILDING ROW

By FRED W. PERKINS
Scripps-Howard Staff Writer

The U. S. Chamber of Commerce is advising a group of physicians today that if they are harmed by union picketing of their offices they can sue the union for damages.

This would be under the "secondary boycott" prohibition of the Taft-Hartley Law. The physicians' case is something new in the way of secondary boycotts, which is a labor-union tactic sometimes involving innocent third parties in efforts to win labor disputes.

Both sides agree on the general facts: That the Napa (Calif.) medical group, six physicians operating as partners, hired a union contractor to put up a new medical center for them.

PICKETING

The union picketed the building site and also the doctors' offices; made and published lists of the automobile license numbers of the doctors' callers; and urged the doctors' patients to seek medical attention elsewhere.

Napa, near San Francisco, is the home of Dr. Dwight Murray, president-elect of the American Medical Association. His name does not appear in either the statements of the Napa County Building Trades Council (AFL) or in the plea for advice of the medical group to the U. S. Chamber of Commerce.

Glendon M. Conner, business manager for the group, wrote to the chamber that the contract was awarded to George Davidson, of Loma Linda, Calif. —a brother of one of the six physicians—because he submitted a bid $10,000 under the estimate of a Napa contractor.

Mr. Conner declared contractor Davidson was informed "that he was to give all possible preference to local sub-contractors in doing his work, inasmuch as many of them are friends and patients of the doctors."

Mr. Conner added that Mr. Davidson did contact a number of subcontractors, union members, "who expressed definite interest" but declined the invitation because they were unable to cross picket lines.

"The natural result," Mr. Conner wrote the chamber, "was that the union has forced Mr. Davidson to go entirely non-union.

"The doctors feel," he continued, "that actually they have no dispute with the union. A legal contract has been signed with the contractor and if the union wishes to picket him that is its privilege."

—*The Washington Daily News*

FAIR ENOUGH

Many undoubtedly aren't going to be happy about the solution proposed by the Vanderburgh County Medical Society for administering the scarce supply of Salk polio vaccine.

In the first place, there isn't enough vaccine for an all-out public immunization of every susceptible person. In the second place, the amount of so-called "free" vaccine is even more limited. In the third place, at this time no one knows how much will be available, and when—whether it's available all at one time, or in a series of deliveries.

The politicians will seize advantage of this opportunity to point to "government bungling." Others probably will charge the National Foundation for Infantile Paralysis should have provided free vaccine for everyone. Unfortunately, others will charge the medical profession with trying to bottle up and control the vaccine supply for its own benefit.

In the confusion we shouldn't lose sight of the fact that drug manufacturers licensed to make the vaccine are making as much as they can within the limits of safety, and every community is being entrusted with the responsibility of doing an intelligent job of handling what it can get.

Evansville physicians are proposing that those with adequate proof that they are unable to pay should get the free vaccine—when and if available. Those who can pay will be expected to—when and if.

There isn't much else the doctors could do under the circumstances, and it appears fair enough.

—*The Evansville Press*

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SOCIAL SECURITY ISN'T INSURANCE

Welfare Secretary Folsom recently attacked as unwise the major provisions of a bill to amend the social security act, already passed by the house. He termed unwise or unworkable proposals to lower the retirement age of women to 62 and to pay pensions to totally disabled persons when they reach 50.

This brought from George Meany, president of the AFL-CIO, which backs this legislation, one of those statements made more in sorrow than in anger. It was shocking, Mr. Meany sobbed, to find in a fine progressive like Mr. Folsom "abandonment of the basic insurance principle of the social security program and the substitution of the relief basis for handling cases."

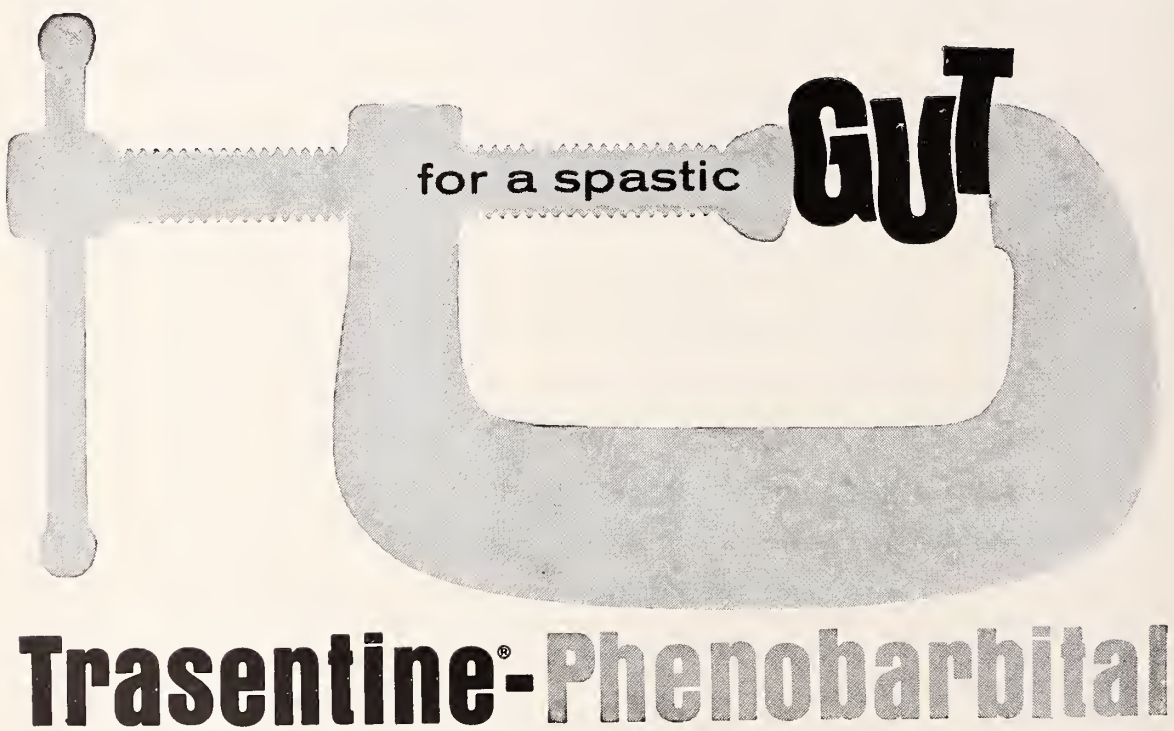
It is somewhat more shocking, after 20 years' experience with social security, to find anyone trying to tell the public that the program has anything to do with insurance, because it hasn't. If the pretense had ever been made that there was any relation between social security taxes and social security benefits, the courts would have been compelled to throw the whole system into the ash-can years ago, for the most casual inspection of the rules establishes that what you pay and what you get are wholly unrelated.

Benefits are calculated at a high rate on low monthly earnings [55 per cent of average earnings up to $110] and at a lower rate [20 per cent] on anything you earn above that minimum. The result, deliberately calculated, is that the better paid worker is taxed to provide a pension for the less competent and the shiftless.

Congress has repeatedly changed the benefit schedule, nearly always, as might be expected, to increase benefits. This is a clear demonstration that there is no contract between the government and the payer of a social security tax, as there is between an insurance company and the payer of its premiums. When Secretary Folsom told Congress that the social security system is in "approximate actuarial balance" he meant only that there is enough money on hand or in prospect to pay obligations as they come due. He didn't mean that any contributor is going to get benefits based on his contributions, because no one is.

Social security consists of a system of taxation and a system of government gratuities. If Congress liked, it could go on collecting the taxes and stop paying the gratuities. Whatever the system is, it isn't insurance.

—*Chicago Tribune.*



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1. Spies, T. D., et al.: GP 12:73, No. 1, 1955. 2. Boland, E. W.: J.A.M.A. 160:613, 1956. 3. Gillhespy, R. O. Lancet 2:1393, 1955.

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INCREASED INTEREST in Indiana as a desirable area in which to establish medical practice is seen in the large number of inquiries received by the Physicians Placement Bureau of the Indiana State Medical Association. Twenty-seven doctors have requested a copy of the brochure "A Place of Your Own Is Awaiting You in Indiana" during the last month. Four communities have made new requests for lists of physicians available to practice in their localities. In March, 21 communities were listed in The JOURNAL.

LOCATIONS

MILLTOWN—Crawford County; community and county with a population of 10,000. Three physicians in county. One physician is leaving for a residency and wishes to have someone take over his practice. Financial help can be obtained if needed. Contact Dr. Claude E. Davis, Milltown.

YORKTOWN—Delaware County; population of Yorktown and Mt. Pleasant Township 5,000. The Community Betterment Committee is interested in finding another physician for the community. Located six miles from Muncie. Contact Mr. Fred H. Marsch, Yorktown.

WHITELAND—Johnson County; population 3,000 with the population increasing because of a building program—800 new homes to be built within the near future. Located five miles from Franklin and 16 miles from Indianapolis. Contact Mr. Marley H. Williams, Whiteland, for details.

ETNA GREEN—Kosciusko County; population 450. Located 12 miles from Warsaw. Community is expanding and the citizens are willing to cooperate with a physician in getting him established. Contact Jene R. Lindsey, cashier, Etna Bank, Etna Green, or Mr. Donald D. Poulson, Etna Green, Indiana.

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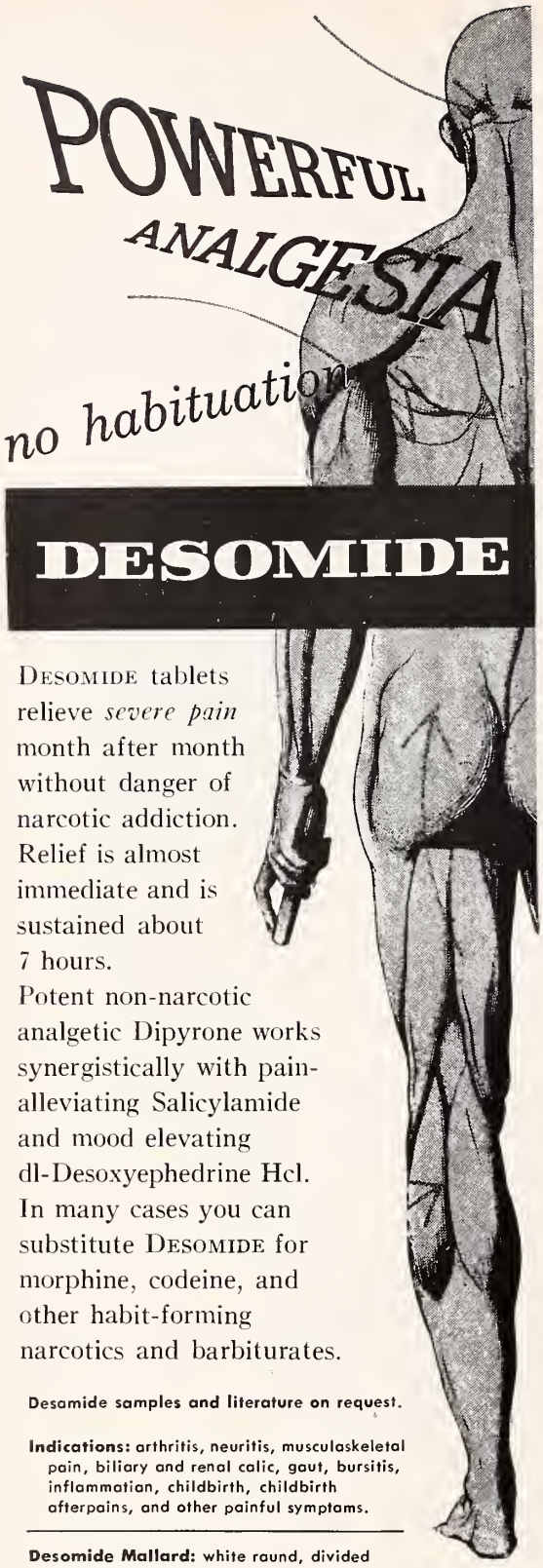
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Gerald E. Hughes, M.D. (general practice) 25 Douglas, Hammond, Indiana.

"...WHEN CONTINUOUS DIURESIS IS MANDATORY TO CONTROL HEART FAILURE, NEOHYDRIN BECOMES THE SUPERIOR [ORAL] AGENT, SINCE THIS COMPOUND CONTINUES TO PRODUCE DIURESIS WHEN ADMINISTERED DAILY"*

*Moyer, J. H., and Hughes, W. M.: J. Chron. Dis. 2:678, 1955.

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Open Letter to the Nation's Doctors

S. Sloan Colt, president of the National Fund for Medical Education, wrote the following message for use preceding Medical Education Week, April 22-28. It was not available in time for use in the April issue.

Mr. Colt's letter is not dated . . . his suggestions are applicable to this year's drive for funds to keep America's medical schools free and to provide funds for research. They are equally good for future years. He speaks for American businessmen to American physicians.

Since its founding in 1949, the National Fund for Medical Education has concentrated almost wholly on obtaining corporation support for the nation's medical schools. Progress has been slow but steady. Each year has seen an increase over the previous one, both in the number and amounts of company contributions. In 1955 more than 1,500 business firms contributed nearly $1,700,000.

It is, of course, a long way from the $10 million additional annual income required by the schools. But it has shown us what is necessary to win corporation support: a painstaking — and persistent — campaign of education to show business leaders their stake in medical education.

The encouraging part of the picture is the readiness of business leaders to support medical education "once they know the facts." As Colby M. Chester, chairman of the Fund's Committee of American Industry, once said: "If we can get them to sit still long enough to listen, we can get their support."

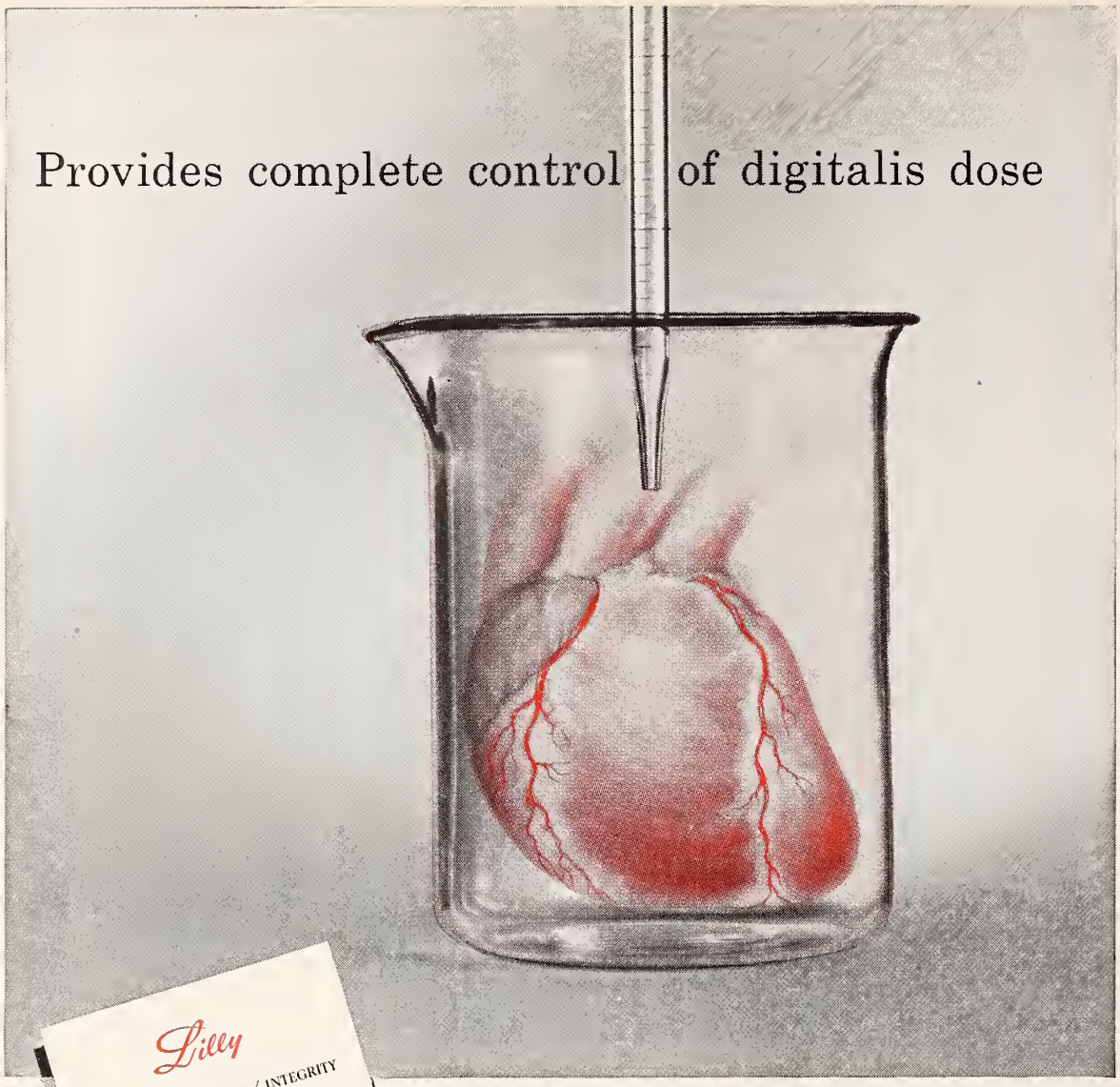
That is the problem. And it brings to mind the happy thought that nowhere is a businessman more approachable, or more likely to "sit still," than in a discussion with his doctor.

Now I am not suggesting that physicians badger their patients for contributions to the Fund. But I am wondering if doctors cannot be a great ally of the Fund in bringing, in some way, the needs of the medical schools to the attention of the businessmen among their acquaintances. Certainly no one is better qualified to speak authoritatively than doctors. And no one could be more convincing.

Medical Education Week, it seems to me, provides an excellent occasion for beginning such an approach. It will be a period when the needs of the medical schools, as well as the achievements of medical science, will be discussed at meetings businessmen attend and in publications they read. Perhaps then, too, the approach can be followed up from time to time during the year.

Considering the role that the medical sciences have played in safe-guarding the people's health, no one has to be timid or reluctant about broaching the subject of continued support for medical education. The testimony of the doctor, coming on the heels of appeals by industry leaders, can do much, in my opinion, to win the businessmen over. Once they are convinced, they are likely to become regular annual contributors to the Fund.

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The Office Management of Problems of Anemia

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INTRODUCTION

EVERY PRACTICING PHYSICIAN is frequently confronted with the problem of a patient who is found to be anemic without obvious cause. The possible etiologies of an anemia are innumerable. It is, therefore, imperative to have at one's command a systematic method of diagnostic approach. It is the purpose of this paper to outline such an approach that is applicable by any physician in his office.

It is first essential to recognize that any anemia is not a disease but only a symptom. It is an indication that some factors are interfering with the normal production of red blood cells, or that there is increased destruction or loss of red blood cells. Anemia is a symptom of many varied and diversified diseases involving all the body organs and systems. The finding of anemia should, therefore, serve only as a spurring-on to an assiduous search for the fundamental disease process. The advances of clinical science have made it possible to think in precise terms and to discard vague, non-defined terms, such as primary or secondary anemia. Many anemias fall into the broad category of nutritional, but it is possible to think in terms of definite nutrition factors.

Looseness in clinical thinking is also prompted by the all-purpose hematinics that are presently flooding the drug counters. Some of these are advertised to cure all the "treatable anemias", and imply that the use of these preparations will dispense with the need for diagnostic acumen. These subtle attempts to reduce physicians to the status of medical technologists are but a fraudulent attempt to avoid good medical practice. Some of the reasons why these preparations are useless and harmful may be considered.

1. They are completely ineffective in most anemias.
2. Time lost in the use of these preparations may indefinitely delay urgent diagnostic

measures in anemias due to systemic disease.

3. Administration of large doses of iron to an anemic, but non-iron deficient, patient may result in excessive absorption of iron, leading to hemosiderosis or eventually hemochromatosis.

4. "Shot-gun" preparations completely confuse the therapeutic response, which should be the confirmation of original diagnosis.

5. Iron-deficiency anemia frequently is the presenting sign of intestinal neoplasm, ulceration, etc. Preparations containing iron will correct the anemia and may cause neglect of more thorough diagnosis.

6. Failure to diagnose pernicious anemia may cause continued therapy to be neglected and relapse with neurological manifestations may occur.

7. Preparations containing folic acid but insufficient in vitamin B-12 will temporarily palliate the anemia of pernicious anemia, but may precipitate neurological manifestations.

8. All this is accomplished at increased expense to the patient. Accurate diagnosis and treatment is invariably less costly in the long run.

The literature on the various aspects of the anemias is voluminous and more detailed information may be found in various textbooks.[1, 2] For ordinary clinical practice the basic techniques and concepts may be briefly outlined. As in other medical disciplines, the art of diagnosis is based on the accumulation of pertinent facts and their judicious interpretations. Once that diagnosis is established sound management may be intelligently applied.

TECHNIQUES OF FACT FINDING

Since the anemias are a reflection of such a wide variety of disorders, a good medical history and thorough physical examination are essential. In hematological diagnosis it is also mandatory that the blood be carefully examined. It is in this part of the examination that there are the greatest errors of omission and commission. For those who know how, examination of the blood is easy. The techniques are simple and can be quickly mastered by any physician and his technician.

First, it is important to establish the presence or degree of anemia. There are three common methods of enumeration of the red cell substance concentration in the blood: the red cell count, the hemoglobin and hematocrit determinations. The most widely used, but most inaccurate, method of enumeration is the red cell count. It is probable that most physicians do not realize the inaccuracy of this determination. It has been extensively studied and it has been shown that the minimum error is at least eight to ten per cent.[3, 4] If ten successive counts are done on the same blood, one may expect a difference of 1,000,000 cells between the highest and the lowest count. Any so-called accuracy of technicians in performing counts has been shown to be due to unconscious bias in making counts agree with each other and with more accurate methods of determinations.[4, 5] Surely, with such an inaccurate method, it is most difficult to know if anemia is present at all and impossible to draw conclusions as to the type. The only way the accuracy of this method may be increased is to average the counts from multiple pipettes and counting chambers, which is extremely wasteful of technician time. Routine use of the red cell count may be quickly discarded without loss of diagnostic usefulness.

Methods of determination of hemoglobin concentration by direct visual comparison are also very inaccurate.[4, 6] Recently the use of photometers and spectrophotometers has brought a reasonable degree of accuracy to this determination, but errors of 0.5 to 1.0 gm. must still be expected. Determination by the cyanohemoglobin method may improve the accuracy of direct hemoglobin estimation but is not yet ready for clinical or office use.[7]

Fortunately, the most accurate method of estimation of red cell substance concentration in the blood is also the easiest. The hematocrit has come to be the test most relied upon by those experienced in examination of the blood. All agree that the margin of error of this determination is less than one percent.[1, 4] This measurement is thus highly accurate and readily reproducible in the hands of anyone with the least laboratory experience. Macroscopic examination of the centrifuged blood in the hemocrit tube also discloses other valuable information. The volume

of packed white cells and platelets is measured. The color and opacity of the plasma may be seen, so that jaundice, lipemia or the presence of hemoglobin or one of its pigment derivatives in the plasma may be detected. The hemotocrit method is readily adaptable to large or small laboratories and provides a maximum of reliable information for a minimum of effort.

Microscopic examination of the blood cellular elements is essential. For this purpose the cover slip technique is preferable.[1] When examining any blood smear it is important to routinely observe the red blood cells and platelets as well as to do the white blood cell differential. Observations of the erythrocytes are even more important when anemia is present. One should carefully look for deviation from the normal size, shape, and color, and with a little practice, significant abnormalities can be accurately determined. Direct observations of erythrocyte abnormalities are much more reliable than the indices obtained from inaccurate red blood cell counts. It is also important to know if the cells are uniform or if there is marked variation in appearance. With a little practice, deviations from normal size or color can quickly and accurately be noted. Target cells, stippling or nucleated red blood cells may be found. The physician who makes the practice of personally, microscopically examining the blood in all cases of anemia will find the small time spent richly rewarding.

In most cases of anemia a reticulocyte count should also be done. There are dry and wet techniques of doing this.[1] By any technique the accuracy of the count is poor, but since the normal reticulocyte count is less than one per cent, and one is mostly concerned in knowing merely if the percentage is abnormal, high degrees of accuracy are not necessary. It is necessary to know when and if reticulocytes are present in the blood in abnormal numbers.

These are laboratory examinations that may be performed in any office laboratory. There are many other types of more detailed tests that may be used to better delineate a type of anemia. Some of these can be adapted for office use such as sickling, fragility and hemolysin screening tests. Others require the services of a larger laboratory, hospital or medical center. Such facilities are necessary for only a small percentage of anemias. Use of the few, simple procedures outlined will enable every physician to deal intelligently with problems of anemia.

INTERPRETATION OF FACTS AND THEIR APPLICATION

There are almost as many different classifications of anemia as there are authors. There are merits to each system. The following classification is felt to be of value from the standpoint of diagnostic approach and therapeutic application.

DIAGNOSTIC CLASSIFICATION OF ANEMIA

Type I—Normocytic, normochromic anemia without reticulocytosis.
- a. Chronic disease.
- b. Primary bone marrow pathology.
- c. Diseases of massive splenomegaly.
- d. Certain metabolic disorders.

Type II—Anemia with significant reticulocytosis.
- a. Hemolytic anemia.
- b. Rejuvenating anemia.

Type III—Hypochromic anemia without reticulocytosis.
- a. Iron deficiency.

Type IV—Macrocytic anemia without reticulocytosis.
- a. Non-megaloblastic.
- b. Megaloblastic.

The various types may now be further considered.

TYPE Ia

The most common chronic diseases causing anemia are neoplasm, renal disease, liver disease, tuberculosis, various granulomata, rheumatoid arthritis, sub-acute bacterial endocarditis and others that adversely affect the total body metabolism. In these disorders the red cells are usually normal or sometimes slightly microcytic in appearance. The anemia is mainly due to insufficient production of red blood cells by a morphologically normal bone marrow. The discrete pathways by which the metabolism of the bone marrow cells is interferred with are unknown. Therapeutic consideration should be given primarily to the underlying disease, and in such treatment the persistence or disappearance of anemia is often a useful therapeutic sign.

Use of the usual "hematinic" agents in these conditions is confusing, wasteful and ineffective. Physiologically, huge doses of cobalt salts will usually ameliorate the anemia to some degree,[8, 9] but they are often poorly tolerated by the gastrointestinal tract and have been reported to cause hypothyroidism.[10] Use of cobalt should be restricted to conditions in which there is no satisfactory therapy available for the primary disease and the anemia is symptomatic.

TYPE Ib

In all cases of normocytic, normochromic anemia without reticulocytosis and in which there is no discernible chronic disease, attention should be directed to the bone marrow itself. Marrow aspiration or marrow biopsy should be done in all such cases to directly examine these tissues.

Aplastic anemia is a term that is applied whenever there is morphological or functional suppression of bone marrow cells. The pathology may vary from complete marrow aplasia to marrow hypercellularity.[11, 12] Examination of the blood shows varying degrees of anemia, granulocytopenia and thrombocytopenia without significant abnormality of the cells present. Aplastic anemia may rarely occur idiopathically, but in most cases history of possible toxic exposure may be elicited. Ionizing radiation of any sort, innumerable organic chemicals and various heavy metals have been shown to produce this syndrome. In recent years, the most common offending agents have been various chemotherapeutic agents. The first essential of therapy is the detection of any possible toxic agents and their removal from the patient's environment. Some cases will have spontaneous remission, and some will respond to steroid therapy, so that a vigorous trial of these drugs is indicated.

Myelophthisic anemia is seen when there is structural invasion of the bone marrow. It is most commonly seen in leukemias, lymphoma and metastatic carcinoma and is distinguished by the finding of nucleated red blood cells in the blood without evidence of hemolytic activity. A most bizarre blood picture is seen in myelofibrosis. There is anemia with bizarre and nucleated red cells on the smear and also thrombocytosis and a leukocytosis. The leukemias may be treated with one of the anti-metabolites and some cases of metastatic carcinoma by hormones.

TYPE Ic

Anemia may be found in association with many diseases in which considerable splenomegaly occurs. The most conspicuous example of this phenomenon is in chronic congestive splenomegaly (Banti's syndrome). Usually the leukopenia and thrombocytopenia is of greater concern than the anemia.

TYPE Id

Normocytic, normochromic anemia occurs in severe scurvy, but probably only when there are borderline deficiencies of other vitamins.[13] Ascorbic acid plays an indirect role in macrocytic anemia of childhood as will be discussed later. Pellagra is sometimes associated with anemia,[14] but there have been no reported cases of anemia in man due to pure deficiencies of any of the B vitamins other than folic acid or B-12.[15, 16]

Proper function of the pituitary, the thyroid, and possibly the gonads, is necessary for normal erythropoiesis.[17, 18, 19] Anemia is part of the clinical syndromes of myxedema and hypopituitarism.

TYPE IIa

The hemolytic anemias are a complex, heterogeneous group and will be scarcely more than mentioned in this writing. They may be variously classified, but in general may be divided between the hereditary or intracorpuscular defect group and the acquired or extracorpuscular group.[20] The acquired group may arise idiopathically or be secondary to some disease. Excessive red blood cell production and destruction are common to all. Clinically, hemolytic anemia is distinguished by the presence of persistent anemia, reticulocytosis and jaundice. There are specific diagnostic tests for all of the hemolytic anemias as we now group them, but they usually require the services of a special laboratory.

There are certain therapeutic considerations. Splenectomy is of benefit when that organ is the principal site of red blood cell sequestration or antibody production.[21] Only in hereditary spherocytosis is such a condition invariably present. Thus, only in hereditary spherocytosis is splenectomy completely effective in stopping the hemolytic activity and preventing future complication.[22] In most other of the hereditary, intracorpuscular hemolytic anemias splenectomy is

without benefit. Unfortunately, in the remaining or acquired hemolytic anemias it is impossible to select pre-operatively the patients who will respond to splenectomy. Steroid therapy is usually beneficial in hemolytic anemia due to autoimmune phenomena.

TYPE IIb

Reticulocytosis *per se* does not classify an anemia as hemolytic. In the absence of evidence of blood destruction (hyperbilirubinemia, etc.) reticulocytosis usually indicates rejuvenation. It occurs following acute blood loss and it usually occurs when the cause of the anemia has been quickly corrected. The reticulocytosis following B-12 administration in pernicious anemia is well known. Reticulocytosis may just as dramatically occur when deficiencies of iron or folic acid are corrected. In these instances, the reticulocyte response is useful in helping to prove the initial diagnosis.

TYPE III

Hypochromic anemia of severe degree is virtually pathognomonic of iron deficiency. Deficiencies of copper or pyridoxine cause hypochromic anemia in experimental conditions, but have never been observed in man.[15, 23] The anemia of thalassemia shows as much hypochromia, but target cells and a reticulocytosis serve to differentiate the two. Several points should be emphasized about iron deficiency states.

Iron is the essential element of hemoglobin and is necessary in reasonably large amounts for normal hemoglobin formation. The normal adult body contains three to four grams of iron and about half of this iron is incorporated in hemoglobin.[24] Anemia occurs in iron deficiency only after body stores of iron have been depleted. Absorbed iron is used for hemoglobin formation before body stores are replenished. Iron is vigorously conserved by the body, so that the non-bleeding adult does not lose more than one milligram of iron per day. At this rate, were iron to be completely eliminated from the diet, it would take a normal adult three to six years to become anemic.[25, 26] Therefore, it may be said as a dictum, that iron deficiency anemia in the adult is always secondary to loss of blood from the body. The only time that iron deficiency anemia can develop from dietary inadequacy of iron is during the period of growth, when the red cell mass is continually increasing, and during the reproductive period of females, when the normal physiological functions of childbearing and menstruation cause excess drain of body iron. Even then anemia usually increases the percentage of dietary iron absorbed,[27] and iron deficiency anemia rarely develops in well-nourished individuals unless the demands are great. It is, therefore, imperative that the source of bleeding be ascertained precisely in every case.

The treatment of iron deficiency anemia is merely the administration of large doses of ferrous salts of iron over a protracted period of time. There is no advantage between the various iron salts and there is no evidence that the incorporation of any other inorganic element improves iron utilization. The only agents that will aid iron absorption are reducing agents such as ascorbic acid that keep the iron in the ferrous state.

If further blood loss has been prevented, the response to oral iron, in doses of one gram daily or larger, should be apparent in about 10 to 12 days. Complete restoration of normal blood values may require 6 to 10 weeks of therapy, and if it is desired to replenish body iron stores, therapy should be continued for months. Once the anemia has been corrected, its recurrence is a certain indication that further bleeding has taken place. In iron deficiency anemia oral iron therapy may be slow, but it is safe, sure, and inexpensive.

In rare cases in which therapy by mouth is not possible or when the need is urgent, iron may be given by vein. The response to intravenous iron is rapid. Within a few days a reticulocytosis appears and the hematocrit and hemoglobin rapidly return to normal. It is best to start therapy with a daily dose of about 25 milligrams of iron and to increase to 100 milligrams daily. Total doses of 500 milligrams to 1 gram will usually suffice to correct the anemia. If no improvement is noted on this dosage, then further iron will not be beneficial and the original diagnosis must have been wrong.

There is a slight hazard in the use of intravenous iron, but it is still safer than blood transfusion. It should be reserved for patients with severe clinical symptoms or in whom surgery is necessary.

TYPE IVa

The macrocytic anemias are divided into the megaloblastic and non-megaloblastic; therefore,

bone marrow aspiration should be done in every case. Non-megaloblastic macrocytic anemias may be seen in chronic liver disease, hypothyroidism and rarely in certain neoplasms. The etiology of the macrocytosis is not precisely known in chronic liver disease, but it may be connected in some way with abnormalities in the metabolites concerned in erythrocyte maturation. Administration of vitamin B-12 or folic acid is without effect. The anemia of myxedema is typically described as macrocytic, although it may also be normocytic. It is readily corrected by thyroid extract. Rarely, some leukemias may present with a macrocytic anemia and even have cells resembling megaloblasts in the marrow. Macrocytosis may also be found in states of rapid blood regeneration such as during hemolytic anemias and recovery from acute blood loss.

TYPE IVb

Deficiencies of only three factors are known to produce a macrocytic, megaloblastic anemia in man. These factors are ascorbic acid, folic or folinic acid (citrovorum factor), and vitamin B-12.[28, 29] These three factors are apparently intimately connected with nucleic acid synthesis in a complex way.[30] Folinic acid and vitamin B-12 are necessary catalysts or coenzymes for several steps in the synthesis of purine and for conjugations in the production of nucleic acid. Ascorbic acid probably is concerned with the maintenance of proper intracellular oxidation-reduction potentials to allow for better functioning of these catalysts.

Ascorbic acid deficiency is important only in the megaloblastic anemia of infancy. Careful study of these cases prompts the conclusion that ascorbic acid deficiency plays its role by increasing the need and demand for folic acid.[31, 32] Administration of large amounts of folic acid will quickly correct this anemia, and ascorbic acid deficiency in the adult is not associated with megaloblastosis.

Folic acid and vitamin B-12 are intimately intertwined in normal erythropoiesis. Deficiencies of either one will result in a macrocytic, megaloblastic anemia. Vitamin B-12 is also necessary for proper metabolic function of neurons in the central nervous system. The long axon neurons of the dorsal and lateral columns of the spinal cord are most dependent upon vitamin B-12 and prolonged deficiency may result in neurological deficit. Both these vitamins are necessary in but tiny amounts and they are found in most animal protein foods.

Deficiencies of these vitamins are seen as a result of dietary inadequacy and of intestinal malabsorption. Stress situations, such as infections, acute blood loss, growth and pregnancy increase the need for these vitamins, so that a pre-existing sub-clinical deficiency may become symptomatic. Nutritional megaloblastic anemia is seen only when the diet is deficient in animal protein.[33, 34] It is most commonly seen in areas of poverty such as India and other tropical nations. With improving economic conditions nutritional macrocytic anemia is becoming rare in the United States, and is usually only seen in food-faddists and in persons ignorant of dietary rules. In those of normal economic ability and food intelligence, macrocytic anemia is almost always due to an absorption defect.

Absorption defects for either folic acid or B-12 may be found in association with the sprue syndrome,[35] or cases of intestinal stricture or blind loops.[36] A pure absorption defect for B-12 occurs following total gastrectomy[37] and in fish tapeworm infestation (Diphyllobothrium latum),[38] which is seen mostly in Scandinavian countries.

The most common absorption defect (and undoubtedly the commonest cause of megaloblastic anemia) in the U.S.A. is that seen in the disease pernicious anemia. The basic concepts of pathogenesis and therapy of this disease have been elaborated over the past 25 years.[39, 40] Pernicious anemia is due to a specific absorption defect for vitamin B-12. It is usually manifest during adult life, but rarely may develop before adolescence.[41, 42, 43] It is invariably associated with achlorhydria. It is perhaps the one chronic disease in all medicine that is completely manageable. The parenteral administration of only one microgram of B-12 per day will completely prevent all manifestations of the disease and this administration may be done at intervals of from 6 to 16 weeks.[44, 45] Aside from these injections the patient may lead a completely normal life. There are preparations of intrinsic factor and vitamin B-12 for oral use, but they are looked upon with disfavor by most authorities on the disease.[46]

Despite this ease and excellence of therapy, pernicious anemia too frequently is not treated as well as it deserves. Diagnosis may not be well

established or the patient not well informed, so that therapy is discontinued. The ubiquitous use of folic acid presents a more serious problem. Folic acid will temporarily correct the hematological manifestations of pernicious anemia, but it also hastens the neurological manifestations.[47, 48, 49, 50, 51] There has been one report of a group of patients who had developed the neurological complications of pernicious anemia, but in whom the anemia had been masked by the use of multivitamin pills containing folic acid.[52] The correct diagnosis was not found until much of the neurological disease had become permanent. This series is now almost triple in size.[53] More recently it has been objectively demonstrated that the oral administration of folic acid decreases serum B-12 levels in pernicious anemia patients being treated with parenteral vitamin B-12.[54] The administration of folic acid to pernicious anemia patients therefore would seem to be definitely contraindicated. Vitamin B-12 is the only therapy necessary in pernicious anemia and the use of folic acid may only cause complications.

In the absence of more precise information, it would thus seem prudent to give every patient with megaloblastic anemia a therapeutic trial of vitamin B-12. By observing the therapeutic response (or lack thereof), one can definitely establish the presence or absence of B-12 deficiency. When the response is absent or incomplete, one can then administer folic acid and again observe the therapeutic response. In this way the need for either or both of these vitamins may be precisely ascertained.

CONCLUSIONS

1. The use of a scheme such as the one outlined will enable any physician to rationally manage almost every patient found to have an anemia. Only a few patients will require more complete diagnostic study than he is able to provide.

2. It may also be noted that there is no place in this scheme for the "shot-gun" preparations. At best, they may be described as expensive placebos.

3. It is important to remember that in patients with slight anemia, in which there is no detectable bleeding or bone marrow pathology, it is better to wait patiently than to run helter-skelter from one therapeutic agent to another.

4. Accurate diagnosis is always feasible; it is good medicine, and it is economical to the patient.

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Surgery for Spontaneous Intracranial Hemorrhage

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INTRACRANIAL HEMORRHAGE may occur spontaneously due to a variety of lesions. This paper deals with situations in which surgery is indicated.

RUPTURED ARTERIAL ANEURYSM

The majority of intracranial arterial aneurysms are congenital in origin. These aneurysms occur predominantly in or near the circle of Willis. Rupture occurs mainly in the 20 to 40 year age group. In this age group rupture of a congenital aneurysm is by far the most common cause of spontaneous subarachnoid hemorrhage. Beyond age 40, bleeding associated with essential hypertension becomes more prominent.

Acts of straining, such as defecation, coitus, heavy lifting, or trauma may precipitate the hemorrhage, but rupture of the aneurysm may occur while the patient is at complete rest. Almost invariably the patient experiences sudden severe pain in the head when the rupture takes place. The patient may or may not lose consciousness. Of the neurological defects accompanying ruptured aneurysm, 3rd nerve paralysis is the most common. Stiff neck develops within a few hours of the onset of hemorrhage. Bloody or xanthochromic spinal fluid confirms the suspicion of subarachnoid hemorrhage. Arteriography usually shows the precise location of the aneurysm. Complete pre-operative study includes bilateral arteriography of the carotid and vertebral systems, which can be done by percutaneous puncture of the appropriate artery.

Ligation of either the common carotid artery or the cervical portion of the internal carotid artery is the simplest form of surgical therapy for ruptured aneurysm. Internal carotid ligation results in hemiplegia in about 8 per cent of cases[1] but the incidence of this complication is negligible when common carotid ligation is done.[2] Recurrent hemorrhage after carotid ligation takes place is less than 10 percent of cases.[1, 2]

Intracranial procedures such as application of a silver clip to the neck of the aneurysm or ligation of the artery just proximal and distal to the artery carry a relatively high operative mortality because the aneurysm may burst during the operation. Deliberate production of arterial hypotension by the use of hexamethonium bromide or Arfonad during the intracranial procedure has made it much safer. In Steelman et al's[3] series of intracranial ligations of aneurysms the operative mortality was only 4.7 percent though others[4] have been unable to attain such a low mortality. With adequate intracranial ligation or trapping the possibility of recurrent hemorrhage is virtually zero.

Non-surgical treatment of ruptured aneurysms consists of absolute bed rest and sedation to avoid elevation of blood pressure. With such therapy the mortality is about 50% during each episode of hemorrhage. Since recurrence of hemorrhage is the rule, the patient has little chance of prolonged survival unless surgical treatment is given, preferably within 3 weeks of the first rupture.

Illustrative Case:

H.F., a 37 year old male, was admitted to the Robert Long Hospital on December 11, 1954. In 1943 he was rejected for military service because of hypertension of unknown degree. He had no symptoms referrable to hypertension. One week prior to admission, while he was

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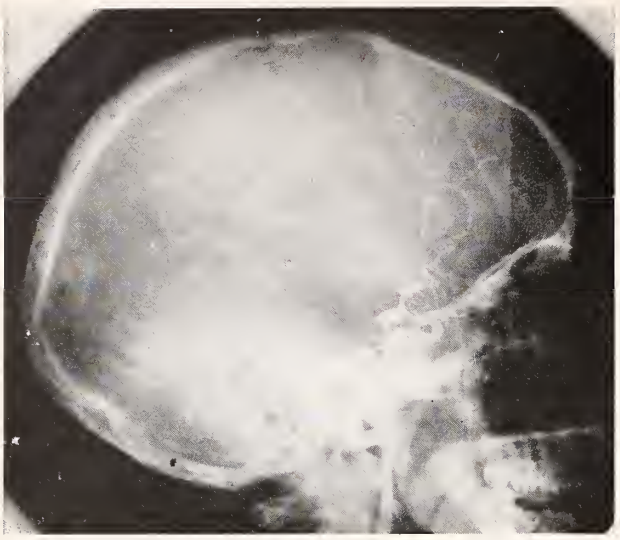


Fig. 1 Lateral view of angiogram of H.F., showing saccular aneurysm on right internal carotid artery.

sitting in a chair, he experienced sudden severe occipital pain. Shortly thereafter he was comatose for one hour. The next two days he was disoriented. He continued to have pain in the back of the head and neck. Examination showed a blood pressure of 160/112, pulse 70. The patient was mildly disoriented. There was definite papilledema confined to the left optic disc. The neck was stiff. There were no localizing neurological abnormalities. Lumbar puncture showed an initial pressure of 290 mm. water. The spinal fluid was grossly bloody. Carotid angiography demonstrated a saccular aneurysm of the right internal carotid artery at the level of the posterior communicating artery. (Fig. 1.) Nine days after the onset of hemorrhage, the right common carotid artery was ligated with a tantalum band, under local anesthesia. Recovery was uneventful, and the patient resumed work as a box-maker 2 months later. During the postoperative period, the patient's blood pressure ranged between 140 and 170 systolic and 90 and 120 diastolic.

Comment:

This case illustrates that it is unwise to assume that all subarachnoid hemorrhage in hypertensive patients is due to the hypertension *per se*. This is especially true of young or middle-aged patients.

ARTERIOVENOUS MALFORMATION (ANGIOMA)

Arteriovenous malformations (angiomas) are congenital and tend to lie in part at least on the surface of the brain. Many of the patients with these lesions have convulsions or other neurological abnormalities even though the angioma does not rupture. When the angioma does rupture, neurological sequelae may be severe. Bleeding may occur into both the subarachnoid space and the brain substance.

In some cases a bruit may be heard, but in most instances only arteriography demonstrates the lesion conclusively. Surgical removal of the angioma is indicated when serious neurological deficit occurs. Excision of angiomas is greatly facilitated by hypotension during surgery.

Illustrative Case:

J.W., a 24 year old female, was admitted to the Robert Long Hospital on September 15, 1952. The day before admission she noted numbness in the left foot and later in the left leg and arm. A few hours later she experienced a sudden excruciating frontal headache. Shortly thereafter she lost consciousness for 5-10 minutes. The headache persisted, and she had two additional periods of brief coma during the next 18 hours. The patient was nine months pregnant, with expected date of confinement September 20, 1952. Examination showed blood pressure 120/80, pulse 56. The neck was stiff. There was hypalgesia of the left half of the body, especially in the left leg. There was slight loss of position sense, stereognosis and localization sense on the left. Lumbar puncture disclosed very bloody spinal fluid with an initial pressure of 224 mm. water. On the day of admission, angiography was performed. This showed a huge arteriovenous malformation of the right cerebral hemisphere. (Fig. 2.) The malformation derived at least a large part of its blood supply from the right internal carotid circulation. A ligation of the right common carotid artery was done the same day. Twelve hours later labor began spontaneously. Emergency cesarean section was done, with delivery of a healthy, full-term female infant. In the succeeding three years, no further bleeding has occurred. The patient continues to have slight sensory loss in the left foot, but is otherwise well and cares for a family of 3 children.



Fig. 2. Lateral view of angiogram of J.W., showing arteriovenous malformation in right cerebral hemisphere.

Comment:

Carotid ligation rarely effects complete cure of a cerebral arteriovenous malformation, since such anomalies frequently derive their arterial supply from more than one major artery. Carotid ligation was done as an emergency measure to reduce the likelihood of further hemorrhage in this gravid woman. Cesarean section was performed to avoid the grave possibility of further hemorrhage during labor.

BRAIN TUMOR

Hemorrhage into necrotic areas within brain tumors may occur, especially in malignant gliomas and metastatic carcinoma. At times the hemorrhage is the first hint of intracranial pathology, and the surgeon is surprised to encounter tumor in the wall of the hematoma cavity. Obviously such tumors will not be diagnosed antemortem unless intracerebral hematomas are evacuated surgically and the walls inspected for tumor.

Illustrative Case:

G.H., a 49 year old male, was admitted to the Robert Long Hospital on January 30, 1954. Three days previously he had a rapid onset of inability to use the right hand in writing, twitching of the right half of the face, difficulty in talking, weakness in the right leg, and headache.



Fig. 3 Lateral view of skull x-ray of G.H. with air in intracerebral hematoma cavity.

The following day he was completely aphasic. Examination at the time of admission showed a stuporous patient with complete right hemiplegia and aphasia and early papilledema. A large lymph node was palpable in the right anterior neck. Lumbar puncture yielded grossly bloody spinal fluid with a pressure of 380 mm. Bilateral carotid angiography was performed the day of admission, but revealed no lesion. On the same day ventriculography was done. During the course of this procedure the ventricular needle entered a large left parietal hematoma. (Fig. 3.) Craniotomy was done and the hematoma evacuated. Biopsy of the wall of the hematoma cavity within the parietal lobe revealed no tumor. Because of persistent increased intracranial pressure, the craniotomy flap was reopened on February 11, 1954, and a recurrent hematoma removed. At this operation biopsies of the wall of the hematoma cavity and of the cervical lymph node both showed carcinoma. The patient expired on February 22, 1954. Autopsy disclosed a malignant pheochromocytoma of both adrenal glands.

RUPTURED MYCOTIC ANEURYSM

A bacterial embolus may lodge in a cerebral artery and weaken the arterial wall, which subsequently ruptures. This is a rare occurrence. The vast majority of cerebral arterial aneurysms are congenital. However, when a likely source of bacterial emboli is present, the diagnosis of mycotic aneurysm should be considered in pa-



Fig. 4. Lateral view of skull x-ray of A.S., with air in hematoma cavity in left parietal lobe.

tients with subarachnoid or intracerebral hemorrhage.

Illustrative Case:

A.S., a 46 year old man, was admitted to the Robert Long Hospital on October 9, 1953. He complained of pain in the right anterior chest for 3 days prior to admission. Chest x-ray revealed a large abscess in the apex of the right lung. On October 22, 1953 he underwent thoracotomy and drainage of the abscess. Culture of the abscess was positive for Friedlander bacillus. On October 31, 1953 the patient suddenly became comatose, with a right hemiplegia. Two days later lumbar puncture revealed bloody xanthochromic fluid with a pressure of 400 mm. On November 5, 1953 skull trephination was done and 30 cc. of sterile, obviously old, blood was aspirated from the left parietal lobe. Air was injected into the hematoma cavity for x-ray visualization. (Fig. 4.) The patient then gradually improved. Coma disappeared in a few days. When seen in the out-patient clinic on May 3, 1953, the patient was well, with no evidence of hemiplegia.

INTRACEREBRAL HEMORRHAGE IN ESSENTIAL HYPERTENSION

Essential hypertension is the commonest cause of spontaneous intracerebral hemorrhage. In patients with hypertension, a "stroke" is usually due to intracerebral hemorrhage. However, in patients with normal blood pressure, thrombosis is far more frequent than hemorrhage as a cause of "stroke".

Typically a patient with intracerebral hemorrhage has a sudden severe headache, quickly loses consciousness and is hemiplegic. Third cranial nerve paralysis is often present on the side of the hemorrhage. If coma is brief, spontaneous recovery may take place. Many cases terminate fatally within a few hours, with development of decerebrate rigidity, Cheyne-Stokes respiration and finally apnea.

If blood enters the subarachnoid space or ventricular system, the patient will have a stiff neck, and the cerebrospinal fluid will be bloody and under increased pressure.

Surgical evacuation of the intracerebral hematoma may benefit some of these patients, but such a procedure is not a panacea. It is probably a worthless effort in patients whose neurological condition quickly deteriorates to decerebrate rigidity within a few hours. Patients with brief coma and early signs of recovery from hemiplegia should also be treated conservatively. Surgical evacuation of the hematoma may definitely benefit patients who survive more than 24 hours, with persistent hemiplegia and increased intracranial pressure.

Illustrative Case:

W.H., a 41 year old man, was admitted to the Robert Long Hospital on February 26, 1953. He was known to have had hypertension for the last 12 years. In 1952 he had an episode of transient weakness in the right arm. Five days prior to admission the patient suddenly became comatose. When he regained consciousness several hours later, he had obvious right hemiplegia and aphasia.

Examination showed a stuporous patient with complete right hemiplegia and aphasia. There was bilateral papilledema. Blood pressure was 200/150. The heart was enlarged. On the day of admission a left fronto-parietal craniotomy was performed and an 8 x 4 x 3 cm. hematoma evacuated from the white matter of the left cerebral hemisphere. Postoperatively the patient became more alert and his aphasia gradually improved. Six months later he could talk in short,

simple sentences. There was little recovery from the right hemiplegia.

Comment:

There was no dramatic reversal of neurological disorder in this case, but the patient's aphasia definitely improved. It is doubtful that this improvement would have taken place without surgery.

SUMMARY

Intracranial hemorrhage may arise spontaneously from such causes as rupture of an arterial aneurysm, rupture of an arteriovenous malformation, bleeding from a brain tumor, rupture of a mycotic aneurysm, or essential hypertension. The appropriate surgical treatment for hemorrhage from these sources is discussed and illustrated by case histories.

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Announcement . . .

After May 10, The JOURNAL will be "at home" at 1019 Hume Mansur Building (just 2 doors from its old offices at 1017).

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Surgery for Traumatic Intracranial Hemorrhage

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INTRACRANIAL HEMORRHAGE is a prime indication for surgery in patients with head injury. This paper is a review of the more common types of traumatic intracranial hemorrhage, emphasizing conditions in which surgical intervention is indicated.

EPIDURAL HEMATOMA

In a typical case the patient receives a blow on the head, causing concussion with coma for a brief period. He then regains consciousness and during this lucid interval seems relatively normal. Within a few hours the expansion of the epidural hematoma compresses the brain. The first sign of the cerebral compression is usually a lowering of the level of consciousness. The patient becomes lethargic, drowsy, disoriented, confused, stuporous, and finally comatose. Progressive contralateral hemiparesis may develop. The pulse may slow and blood pressure rise, but such changes in vital signs can be absent until late. There may be compression of the 3rd cranial nerve, resulting in a pupil which is dilated and fixed to light, usually ipsilateral to the hematoma. When the brain stem is compressed decerebrate rigidity ensues with extension of the extremities. Soon thereafter Cheyne-Stokes respiration develops, followed by complete apnea, and the patient expires. The entire sequence, from blow until death usually lasts 12 hours or less.

Not all patients lose consciousness at the time of the initial blow on the head. Some patients may have coma continuing from the moment of the blow until death, i.e. the lucid interval is absent.

Epidural hematoma is most commonly caused by a linear fracture of the squamous portion of the temporal bone, with laceration of middle meningeal vessels. Blood oozing through the fracture into the temporal muscle causes palpable temporal swelling in a high percentage of cases. X-ray films of the skull usually show the linear fracture of the temporal bone. Less commonly the epidural hematoma arises from laceration of a dural sinus (e.g. superior sagittal or transverse) by a skull fracture.

Prompt recognition of an epidural hematoma is essential for its successful treatment. If the patient is allowed to reach the stage of decerebrate rigidity the neurological deficit may be irreversible. If the hematoma is evacuated soon enough recovery is often dramatic. Patients may regain consciousness immediately after hematoma evacuation and hemiplegia may disappear in a few days. The 40% mortality which still prevails for epidural hematoma is due largely to delay in surgical treatment. Epidural hematoma should be regarded as one of the most urgent of surgical emergencies.

The operative procedure consists of rongeuring a hole in the temporal bone, evacuating the hematoma and ligating the middle meningeal artery with silk, silver clips or by electrocautery.

Illustrative Case:

B.W. was a 12 year old girl who fell, striking her head on the corner of a cabinet at 8:00 p.m. on July 3, 1954. She did not lose consciousness immediately following the blow. Four hours later she complained of severe headache and then

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had a convulsion. She remained comatose thereafter. The patient was referred to Indiana University Medical Center. The emergent nature of the case was made clear, so that the operating room was prepared for action immediately upon the patient's arrival at 3:30 a.m. on July 4, 1954. When admitted to the James Whitcomb Riley Hospital for Children she was comatose and restless. The left extremities moved less than the right. The right pupil was 7 mm. in diameter, as compared with 3 mm. for the left pupil. She had Cheyne-Stokes respiration. Pulse was 45, blood pressure 160/80. There was right temporal contusion and swelling. The patient stopped breathing while her head was being shaved. She was immediately intubated and given artificial respiration. A right subtemporal craniectomy was quickly done and a large epidural hematoma evacuated. The bleeding middle meningeal artery was cauterized. The patient then began breathing spontaneously. She made a prompt recovery, regaining complete consciousness in 4 days. Three months later no neurological abnormality could be detected and the patient was doing well in school.

Comment:

Had surgery been delayed ½ hour longer, this patient would probably have died. In this case atypical features were the lack of immediate coma after the blow to the head, and the abrupt rather than gradual onset of coma after the lucid interval.

SUBDURAL HEMATOMA

Chronic subdural hematoma is caused by laceration of a vein bridging the subdural space. The torn vein thromboses before hemorrhage alone causes fatal brain compression. A semipermeable capsule envelops the hematoma. As the blood disintegrates, osmotic tension increases, water enters the hematoma and it expands.

Adults with chronic subdural hematoma complain of increasingly severe headache. Confusion, disorientation and eventually stupor and coma ensue as brain compression progresses. Sixth cranial nerve paralysis, hemiparesis and convulsions may occur, and papilledema is sometimes seen in adults. Ataxia is rather common. Lumbar puncture may show elevation of intracranial pressure and xanthochromic or even bloody spinal fluid. However, it is not at all unusual for both pressure and appearance of the lumbar spinal fluid to be normal. In infants, convulsions, fever, vomiting and irritability are the most common signs of subdural hematoma. The anterior fontanelle bulges in less than one-half of the cases.

The presence of subdural hematoma must be suspected when progressive deficit in cerebral function occurs, especially following trauma to the head. In the event a patient does not promptly regain consciousness after a head injury, but has deepening coma, subdural hematoma must be suspected.

Suspicion of the diagnosis of subdural hematoma is sufficient justification for executing the proper procedure to confirm the diagnosis. In infants the diagnosis is easily confirmed by subdural tap with a 20-gauge needle inserted through the lateral angle of the anterior fontanelle or coronal suture. In adults exploratory trephination of the skull is the only certain means of establishing the diagnosis. Arteriography or pneumoencephalography may aid in the diagnosis, however.

In adults, drainage of the subdural hematoma through trephine openings is easily done and usually effects a cure. In infants, craniotomy and removal of the membrane surrounding the hematoma is necessary, lest the membrane restrict future brain growth. Complete recovery is the rule following early evacuation of a chronic subdural hematoma.

Illustrative Case:

U.S., a 46 year old man, was admitted to the Robert Long Hospital on October 20, 1952. One month prior to admission he fell, striking the left side of his head, but he did not lose consciousness at that time. One week prior to admission he complained of severe headache. He became indifferent to his surroundings and work. He gradually became aphasic, and the day before admission was disoriented, stuporous and incontinent. Examination showed the patient to be very stuporous, with complete right hemiplegia and aphasia, and early papilledema. A tentative diagnosis of glioblastoma multiforme was made. On the day of admission, ventriculography was performed, revealing a marked shift of the ventricular system to the right (Fig. 1). A left subtemporal decompression then disclosed a huge

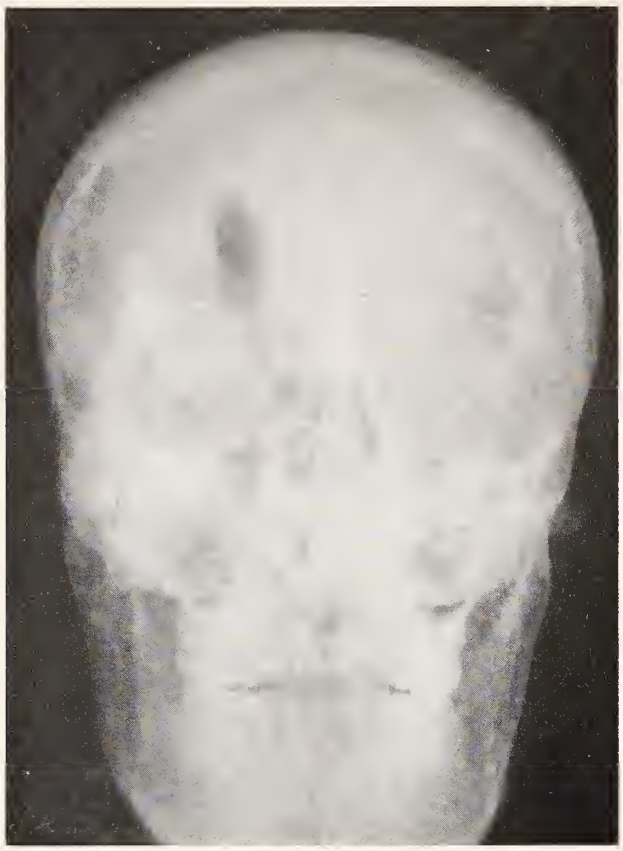


Fig. 1. Antero-posterior view of ventriculogram of U.S. The left lateral ventricle has been compressed and does not fill with air. The right lateral and third ventricles are shifted to the right of the midline because of left subdural hematoma.

subdural hematoma. After evacuation of the hematoma the patient made a rapid recovery. One month later he was feeling well, had no hemiplegia or aphasia, and had returned to work as a bookkeeper.

SUBARACHNOID HEMORRHAGE

Subarachnoid hemorrhage is quite common with severe head injury. The hemorrhage is usually trivial, however, and is not of surgical significance. The underlying brain damage, such as cortical laceration, is of far more importance. Rarely trauma may result in rupture of a previously weakened vessel, e.g. arterial aneurysm, and produce hemorrhage necessitating surgery.

INTRACEREBRAL HEMORRHAGE

Intracerebral hemorrhage in head injury is usually the result of quite violent trauma. Localizing neurological signs, such as hemiplegia or 3rd cranial nerve palsy, may point to the site of the hematoma. Surgical evacuation of the hematoma may be life-saving or may result in recovery of neurological function. The prognosis, however, is necessarily guarded, because these patients have often sustained severe brain damage and there is frequently troublesome cerebral edema attendant to the injury.

The diagnosis is suspected when coma is profound or when localizing neurological signs exist. Tangential gunshot wounds of the head are especially prone to cause subcortical hematoma. The diagnosis may be confirmed by ventriculography, arteriography, or direct needling of the brain after trephination.

Illustrative Case:

P.Y. was a 5 year old boy admitted to the James Whitcomb Riley Hospital for Children on May 1, 1954. Three days previously he was hit by a baseball bat in the right frontal region. There was no loss of consciousness. He vomited frequently after the injury. Examination showed a depressed fracture of the right frontal bone. The patient was lethargic and had mild weakness of the left lower extremity and early papilledema. On May 2, 1954 the right frontal depressed fracture was elevated. A small dural tear beneath the fracture was enlarged with a scalpel. A 30 cc. hematoma was then found in the white matter of the right frontal lobe. After evacuation of the hematoma the patient made a rapid recovery without neurological deficit.

SUMMARY

Bleeding into the subdural or epidural spaces or into the brain itself frequently attends head injuries and necessitates surgical evacuation of the hematoma. Epidural hemorrhage makes prompt surgery mandatory. Patients may make dramatic recovery from serious neurological difficulties if a traumatic intracranial hematoma is evacuated.

Fate, Feeling and Fantasy in the Development of Personality

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I RECENTLY had the good fortune to discuss notes on certain comparative aspects of human cultures with an American school teacher of Chinese origin. Asked about the prevalent attitude toward aging among the oriental Chinese, the teacher replied with the following brief anecdote, "I remember when I was still in China before we came to this country, my mother said to me one day, 'I am 30 years old today. Isn't that wonderful? I shall soon be a responsible adult. I have the feeling that life is just now beginning to have meaning. I am thrilled'."

Can you imagine an American woman saying the same thing? Are we likely to encounter such a point of view in our culture, where 35 appears to be the last admitted age and where the chimera of growing older haunts many into a self-deceptive arrest in the perennial 30's?

There is little doubt but that aging has little currency in our culture. It is resisted, resented and denied. When we think at all about the process of aging our concepts seem vague and hazy. We seem generally to look upon aging as breakdown, loss of purpose, dependency, isolation, melancholy, uselessness and social ostracism. Certainly to very few of us does aging mean attainment of a realm of human social life the entrance into which is thrilling and exciting. There is something bleak about aging in our country. No doubt to many it is synonymous with an outliving of usefulness or death. If such values were intrinsic in the process of growing older, why then has this not been historically true? Why have not the cultures of the Chinese, the Middle Eastern Indians, and the Hebrews embraced similar attitudes toward their aged?

It seems to me that our attitude toward the aged is a recently acquired thing; perhaps something that has developed out of the standards and values that spring from an automated, mechanized, accelerated and philosophically stilted era in human history.

On many occasions I have asked groups of people when they think the prime of life occurs. You would not be surprised to learn that the uniform answer I get from everyone beyond adolescence is that the prime of life is the period roughly between the ages 18 and 35. All that has gone before this period is regarded as preparation for it. All that comes after appears to be treated as anti-climax, a sort of living beyond social usefulness.

I believe that we live in a youth-oriented time. Most of our values are invested in youth. We glorify beauty, agility, change, movement and unbridled ambition—the values of youth.

Are we really concerned with the wisdom of aging? Do we really place any merit in experience or even skill, when machines will duplicate our efforts so readily? Don't we tend to draw a parallel between conservatism and regression? Where is there a place for the counsel of the mature mind, when electronic computing devices can yield foolproof formulae?

WHERE ARE THE ANSWERS?

I believe that as a society we are progressively diminishing the importance and worth intrinsic in human relationships. In so many instances even family life seems guided by rule books and

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equations rather than by the sentiments, feelings and comprehensions that are the products of personal interassociation. The elder hardly has a place in a social system that is jerry-built. And aging, like most everything else, has been added dispassionately as another item in the Do-It-Yourself catalogue.

Where is the authority? Where does one turn for the answers? What constitutes the real repository of judgment? Isn't it entirely conceivable that much of the restlessness of youth so highly publicized today may be the outcome of this diminishing authority in the elder?

The universal concept of the prime of life tells us a good deal. Yet, there is reason for optimism because the currently prevalent viewpoint is based on error. The correct answer to the question "when is the prime of life?" is, "there is no prime of life; there are primes of life." Let us examine the data that lead us to such a conclusion.

Consideration of the popular notion relative to the prime of life leads unquestionably to the conclusion that the period of prime as estimated by many people coincides exactly with the period of greatest sexual interest and child-bearing in the human life cycle. Naturally, such a segment of life is important to the welfare of the race, but I believe that it has assumed an exaggerated degree of importance for a variety of reasons which are not pertinent to our discussion at this time. Values in human life other than sexual and reproductive prowess receive too little attention. If we were to examine other faculties of the human individual which constitute behavior and which are not directly related to sexuality, we discover a number of interesting things.

For example, let us take the sense of hearing. This ability has its prime somewhere between the ages of 25 and 30 and thereafter progressively declines. Vision reaches its peak attainment around ages 17-23 and thereafter is progressively reduced in acuity. The intelligence test, which really makes estimates regarding a very large assortment of different faculties, shows that most people have achieved their maximal scoring around age 25. However, certain subtests within the intelligence test, such as vocabulary, are still on the upgrade of development and have not yet reached their prime even in the 60's. Tests for physical ability show that reaction time is shortest around age 17, but proficiency of performance in tests for muscular ability does not reach its prime until about age 45 and then strikes a plateau for many years.

We could take a very large number of separate faculties and treat them as we have the foregoing. What we discover is that each faculty has a separate prime and that the development of the human mind is really a series of prime attainments. For every quality of the human mind that has reached its highest level of development at any particular stage of growth there is another mental quality that has yet to reach its level of peak achievement.

A NEW PREJUDICE

The whole process of growing up, maturing, and aging can be understood more readily, perhaps, if we strive to clear our minds of the prejudice which our mode of life endows in us. For hypothetical purposes, let us develop what may be described as a new prejudice. Instead of thinking of sexual and reproductive interests as the main values, or even any other particular characteristic of human behavior, let us attempt to describe human growth using as our measuring device a total pattern of behavior representing the results of the coordination, cooperation and integration of all of the particulate faculties into one unified totality. Since maturity must be measured in terms of an individual's orientation toward the society of which he is a part, then would we not be on a sound logical foundation to measure the course of the human life cycle from conception to demise in terms of the individual's departure from the primitive behavior of infancy through the sequences of progressive accession of socially oriented, selfless ways of behaving?

Of course, we have no measuring stick that can be marked off in exact degrees or given numerical values. Nevertheless, we can graph human psychological growth on a table showing increments of age plotted against the factor of social orientation. Social orientation at point zero would be infantile self-centeredness—the epitome of self-interest and the nadir of altruism. The highest level of maturation then would be the quintessence of altruism, or unselfishness, and the nadir of egotism.

Now we do have some philosophical approaches and psychological observations that come to our aid. We know that the course of

human emotional maturation starts in infancy in what may be called *a period of the supremacy of the instincts*. We also know that the social devices, starting with the mother-infant relationship and proceeding through the family experiences, school, fraternal participation and so forth, all constitute a set of circumstances whereby the instincts become educated. The greatest amount of education of the instincts doubtless takes place in the period between birth and the pre-adolescent stage just prior to puberty. Thus on our graph the line of human development that we are drawing will take a sharp upward sweep from zero at birth to a much higher place on our graph by age, say, 11.

Much has taken place in the human mind during those developmental years. The child moves forward from primitivism and indomitable self-centeredness toward aculturation and progressive considerateness for the needs and feelings of others. If we were to divide our whole graph with a horizontal line somewhere at its middle, we could regard that as a critical level below which the instincts are preponderent and above which social behavior is dominant. This critical line is not reached in the earlier periods of life. In fact, there is considerable evidence that suggests that the point of crossing the critical line from instinct domination to social orientation is not reached until approximately age 35. This is about the mid-area of an average human life. Now we may use the well known term *senescence* for the period of life starting around age 35 and proceeding to termination of individual existence. Let us coin a term for the first half of life from birth to 35. This we may call *evolescence*. We are thus afforded an added instrument for communication.

During puberty we find, as we do also at any point of life during which some great physiological upheaval takes place, that there is an increase in the insistance of the instincts and a diminution in the social drives. So that we characteristically discover in the pubertal child that the line of personality development heads downward toward instinct supremacy for a number of months and then starts on the upgrade again as the child enters adolescence.

Until now the child has sought autonomy and independence of purpose and action. Now he seeks self-identity. The boy searches within himself for evidence of manliness. The girl strives at this juncture to become a woman. These needs usher in a period of growth that is characterized by an impulse toward identification, each sex striving to discover factors expected of it and to emulate those social examples that are representative of the goals for striving. During this period of adolescent growth, therefore, we see the real beginnings of social life. The child, who has been alone or dependent, or has run with the pack, now, through a need for complementarity, seeks to pair himself with an individual having opposite qualities. Such pairing leads to the development of the smallest social group, a group of two people with complementary interests. The marriage of complementary interests results in mating and a whole new psychological orientation in the human mind occurs. Our line has been progressing upward at a slow, steady climb, and the first period of true social responsibility, which carries with it an abundance of psycho-social implications is reached. Let us assign to it a label. Let us call it the *period of family creation*.

Since the arrival of dependent participants

***THE SECOND ANNUAL KIRKPATRICK MEMORIAL WORKSHOP ON AGING** was presented at Ball State Teachers College and Indiana University School of Medicine on March 20 and March 21. The workshops were made possible by Dr. Nila Kirkpatrick Covalt's bequest in memory of her parents, J. Walter and Arrena I. Kirkpatrick. Dr. Covalt, now of Winter Park, Florida, spoke at both Muncie and Indianapolis workshops. Coordinator of both meetings was Wilma Donohue, Ph.D., Division of Gerontology, University of Michigan.*

Attendance at the Muncie workshop was approximately 300. Conference participants came from Pennsylvania, Michigan, Missouri, Illinois and Indiana. Registrants represented groups in the health field, industry, labor, social and civic clubs and schools.

Panel discussions furnished broad views of the geriatrics problem. Dr. Linden spoke in Indianapolis on "Psychiatric Aspects of the Problem of Aging."

into the family imposes new obligations on the social unit, the pair, we see an entire new period of social responsibility developing. The parental team must perforce turn some of its selfish interests away from the pair and toward the fostering of the progeny.

By the time the critical line separating the domain of instinct dominance from that of social dominance is crossed and the parents are in their 30's, the issue of this union are passing through the earlier stages of psycho-social maturation. New interests collateral to family life appear on the horizon and a greater turning out of interest from the family itself to the enlarging surrounding world takes place. This is accompanied in the human psyche by a mass of psychological experiences and motivations that may be termed *socially creative,* a second period in human growth in which we see an increase in altruism and a diminution in domination by the instinctual life.

Let us digress for a moment from our consideration of the maturing mind and take note that two of the important factors in mental life, that of the emotional structure and that of fantasy-formations, are operating in tandem with the process of achieving maturity. Feelings give impetus to psychic growth, while they themselves also grow. In this way we see that the feelings of infancy, which were intimately bound up with the child's sense of his own welfare, progressively turn outward to people about him. Self-love increasingly gives way to love of others.

The study of fantasy is an important tool to the student of human nature. As a rule fantasies are not just idle and stagnating day-dreams that represent unfulfilled wishes. Much more significantly, fantasies, or day-dreams as we are wont to call them, represent the stuff out of which ambition and aspirations are fashioned. The fantasies of a 2 year old become the elements of character at age 7 or 8. The fantasies of a 5 year old may contribute importantly to the structure of conscience in later life. A fantasy of an 8 year old may be the impetus for accomplishment in adolescence ; and the fantasies in adolescence may well become the life's work in later years. We are aware also that the fantasies of the adult become the very stuff out of which plans, programs, and operations are created. Perhaps you see the enormous value contained in the psychological capacity for fantasy formation.

Now as we turn back to our graph of the human life cycle and we note that the parental team has reached the socially creative period, we also observe that their fantasy life becomes increasingly orientated toward the realities of social living while the emotions in the ideal case become progressively more unselfish.

What we are creating for ourselves in this exercise is an ideal structural framework within which we may make estimates of what comprises normal maturity at any level of age attainment.

Now we note that as the individual enters more deeply into his socially creative period there occurs an intrusion into the entire pattern by virtue of a new physiologic condition, that of change of life. Such a transition period forces the individual again to turn his mental energies internally, and as an outcome his social awarenesses are held in temporary abeyance. The line on our graph takes a slump at this time in the direction of instinct dominance. In most instances this period is successfully negotiated and the individual emerges from it furnished, as it were, by fate with psychological equipment for finding new values in human existence. For the most part the period of child-bearing is now definitely at an end. The progeny are now in more advanced phases of evolescence and are themselves coming into *family creative* and *social creative periods.*

We may now conceive of the parental team as having risen to a high point on the hierarchical pyramid of responsibilities. The parent is senescent and has a major social obligation toward the evolescents to establish guideposts of living, to offer the fruit of experience, and to select subordinate leaders in the evolescent community. At this period of life were we to compare the province of parental responsibility with geographical subdivisions, we may think of the parents as the chief executives of a state. The lower echelons of the family in the different periods of evolescence are like so many counties, townships, boroughs and hamlets. It would thus be entirely in keeping with our concept to regard the social orientation of the elders at this level of attainment as having entered a sphere of *state creativeness.* Their responsibilities are not for their own comfort so much as for the welfare of on-

***ABOUT THE AUTHOR**—Maurice E. Linden, M.D., a graduate of the University of California School of Medicine, has spent many years of research on mental health and aging. Prior to taking his current post as Director of the Division of Mental Health of Philadelphia's Department of Public Health, he served as program director of the Gerontologic Study Center at Norristown State Hospital, Pennsylvania. He is associate in psychiatry at the University of Pennsylvania Medical School and is in private practice in psychiatry and analysis. He is a fellow and member of American Psychiatric Association and many other professional organizations. He has written numerous articles of gerontologic research and in the field of psychiatry.*

coming generations for whose existence they are responsible. With the objective of achieving maximum welfare the mature elder at this level strives for organization of his family culture. The subordinate leaders, having been chosen, are charged with subordinate responsibilities. The elder possesses the know-how for charting the psychological paths and channels of social growth as well as the traps and pitfalls. We may, therefore, call this period of life a *culture organizational* one. The mature human mind at this juncture has reached a slowly ascending plateau of social consciousness.

Aware as he is through his own accumulated experience of the impetuous and strenuous pleasure-strivings of evolescence, the elder recalls the merit of time-honored social systems and mores. It is as though the older person had rediscovered the civilizing influences in the social evolution of mankind. We may identify this period as one of *moral and ethical reaffirmation.* The pronouncements of the elders are, as we know, rejected to some extent by the evolescent generations seeking independence. An internecine strife becomes evident—a civil war between evolescence and senescence.

The last stage of maturation is one in which the elder, at the zenith of social responsibility, sits as a kind of supreme judge over his subordinate judges and through reflection and selfrevaluation estimates and corrects the conclusions and validities of his own experience. Psychologically, then, this may be regarded as a *period of reflective examination.* This is the period of greatest wisdom, and it would be the last phase of human progress did not further physiologic intrusions occur.

Even more significant are the social intrusions. We see the effects of inexorable biological change progressively robbing the late mature elder of some of his stamina and durability against stress. Simultaneously the older person is beset by an agglomeration of social factors that are all too clear in our culture and that add up to a prevalent attitude of rejection toward the aged.

Now we must remember, as we go back to the beginnings of a human life in the early stages of evolescence, that the developing child at every level of forward movement manifests aggressions, feelings and fantasies of hostility against his elder advisors and educators. We know that the dependent infant who finally grasps the spoon from his mother's hand in order to feed himself has demonstrated early rebellion and an erstwhile effort toward self-mastery. A little later in childhood, during the period of romantic emotional interchanges characteristic of family life, we find developing intense rivalries and fantasies of competitiveness between child and parent. The pre-pubertal child rejects the elders to some extent and seeks solace in juvenile societies. He seeks the answers to his problems in the juvenile gang and regards his older educators as problem-makers. During puberty the tremendous upsurge of instinctual interest forces the elders into the position of prohibitors. The child at this level feels both guilty and angry, and he looks upon the elders as a privileged group who impose arbitrary restrictions. In adolescents feelings of childish inferiority and adult ambitiousness grow into obvious and open rebellion as the evolescent seeks to complement himself and to sever his connection with the elder. Even the young adult, who strives for lofty attainment, entertains fantasies in which the envied elder, who occupies the position of leadership, is eventually thrust aside to be replaced by the evolescent adult.

Even this brief excursion into the emotional and fantasy life of youngsters reveals to us a host of antagonistic impulses against the elders. Added together they constitute elder-rejection. Such feelings are not lost or completely sublimated in the human mind, but tend to become suppressed out of consciousness to take up dor-

mancy and residence in profound areas of mental life.

Returning again to the period of late senescence we discover that the biological and physiological interruptions eventuate in the destruction of some of those defensive devices in the human mentality that were used throughout life to keep the feelings and fantasies of childhood out of consciousness. Such defenses begin to crumble and to lose their effectiveness. Throughout life the psychological defenses have served as a restraining wall against the emergence of unconscious and primitive forces. As the defenses are weakened the hostilities of early evolescence rise toward awareness, but fate presents the late senescent with a grim reality.

The attitudes of elder-rejection, long held in a state of unconsciousness, begin to flood consciousness. When feelings of elder-rejection are found in the elder, the result is self-rejection. To this internal sense of elder-rejection is added the pervasive cultural atmosphere of elder-rejection and the forces in opposition to the elder are seen to become overwhelming. As a consequence we find that our line of upward social growth and maturation takes a slump, from which there is often no recovery.

The ensuing stages in late senescence are only too well known to us. The instincts become deeducated and social thinking in the late senescent begins to deteriorate. Through surrender to sundry forces the elder's mental integration plummets toward instinctual supremacy. All that was laboriously gained in early evolescence is progressively lost and senility becomes the psychological organization. What we have just been describing indicates that senility is not precisely second childhood, but more accurately it is childhood in reverse. It is a psychic state that corresponds roughly to the stages from puberty to foetal infancy through serial phases of de-development that we know as the senile person.

Much of what we have considered consists of relatively rigid factors in childhood development that are refractory to change. But there is much that can be done to alter the too prevalent social situation we see today among the aged. The social factors of rejection must be replaced in time with a return of attitudes of elder veneration. Our one-sided society that places exaggerated emphasis on only a part of man's mental capacities must be educated to rediscover the numerous social values in the senescent mind and the enormous potential for cultural contribution and social betterment that is now untapped in many individuals.

In the March 1956 issue of "The Scientific Monthly" I ran into an unusually insightful passage by Dr. Garrett Hardin, a microbiologist, whose analysis of our social situation as related to mental attitudes that are reflected in languages is remarkably pertinent to our considerations. He writes, "We find a . . . poignant example of the restrictive aspects of idiom in the emotional reactions to old age incorporated in various languages. The meaning of the French *vieillard*, the Spanish *viejo*, and the German *alte*—all terms implying respect and affection—is certainly inadequately represented by the English *old man*, which implies the decrepit rather than the venerable. Do we have such a poor opinion of old age because we have no simple honorific words for it? Or do we have no words for this status because we do not honor it? Probably a bit of both. We are faced here with a vicious circle of attitudes and words, the breaking of which is essential to a successful program of social geriatrics."

The depressing realization of worthlessness which heralds the onset of senile breakdown must give way to self-acceptance in older people. It is entirely conceivable that our society can eventually reach the goal in which the achievement of social seniority will constitute for all of us a thrilling experience.

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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COST OF HOSPITAL CARE

IT IS PREDICTED by good authority that hospital costs will increase at the rate of about 5 per cent annually for many years.

Ray E. Brown, president of the American Hospital Association, discusses the problem in a recent issue of HOSPITALS, and states that only the combined efforts of hospital administration and medical staffs can keep the gradual increase to as low a figure as 5 per cent. A decided worsening of the general economic situation is the only development which Mr. Brown thinks might prevent the upward trend in hospital expenses.

His reasoning is based on the fact that a very large proportion of hospital cost is attributable to wages and salaries. Business and industry in the future will profit by productivity gains, and its workers will improve their pay scales as a result of these gains in industrial efficiency. Since hospitals have no prospect of gains similar to those based on productivity, and since hospital salaries are affected by general salary levels, the cost of paying hospital personnel will inevitably increase.

"Over the years ahead, as the general labor force continues to receive its rightful share of the proceeds from increased productivity, hospitals will be compelled to give equal increases in salary without comparable benefits from increased productivity."

The fact that the average number of hospital employees per patient is on the increase, and the fact that industry is attracting female help, which constitutes about 80% of hospital personnel, adds to the problem and tends to increase hospital personnel costs. Since 1946 hospitals have had to recruit employees at five times the average for all other employers.

The value of such an analysis is twofold. Such a prospect should impress everyone with

the importance of utilizing hospital care as efficiently as possible. It will also be of benefit for this information to be widely disseminated. The public, in particular, should gain a lot in understanding the economics of hospitals, and if they understand should be more tolerant of increasing costs and the various other problems involved.

VA VOLUNTARY SERVICE

AT THE CLOSE OF WORLD WAR II Veterans Administration Hospitals were practically flooded with offers from people of all walks of life who wanted to assist on a voluntary basis in the care of disabled veterans. Last month was the tenth anniversary of the organization of this spontaneous movement into a coordinated program.

At first the volunteer work was performed in an informal and rather unorganized manner. However, the growth of the service was so prompt, and its usefulness so apparent, that it was planned on a nationwide basis, and formally organized on April 15, 1946.

Since then the number of volunteers and the time which they contribute has increased, and is still increasing. During the first year 55,000 men and women each month gave their services for a total of 3,000,000 hours. Now the volunteers average 86,000 per month and in 1955 they tallied 5,650,000 hours.

Originally the work done was mostly along recreational lines. As the program developed the volunteers assisted with nursing, physical medicine, rehabilitation and social service. The volunteers have never replaced the regular hospital staff members, but have added their help to the basic services for which the hospitals were intended.

The VA Voluntary Service program has been a success from the start. One of the most important by-products of this activity has been the installation into hospital life of the bonds of community and home life. For the disabled veterans, and especially for those with long hospital stays, it has brought the conviction that their rehabilitation was not only the concern of the government but was also the concern of private citizens who have been ready and willing to devote their spare hours to the task.

Recently an extension of the Voluntary Service has been instituted on a trial basis. Community volunteer, social and health groups are planning a program to assist each discharged patient who needs it to readjust to home and community life. This is a continuation of the Voluntary Service program in the hospital and is coordinated by a hospital committee to provide help for the veteran for his continued treatment, adjustment to home and assistance in finding and fitting into a job.

The new program has recently been extended to 23 VA hospitals over the country, including the hospitals at Indianapolis and Marion. It may be adopted eventually by all the 173 Veterans Administration hospitals.

DEAN OF MEDICAL EDITORS DIES

DR. W. EDWIN BIRD, of Wilmington, Delaware, who died suddenly on March 17, was, in years of service, the dean of editors of state medical journals. In January he began his forty-first year as editor of the Delaware State Medical Journal. In addition, he had served as executive secretary of his state medical society for the last eight years on a parttime basis. Delaware's physicians retained him as editor for almost a half-century in recognition of his sincerity of purpose and determination to bring good scientific material to his publication's readers.

Guest Editorial:

The editorial "Polls and Public Opinion" is reprinted from the March 1956 issue of The Wisconsin Medical Journal, official publication of The State Medical Society of Wisconsin.

POLLS AND PUBLIC OPINION

"SCHRUBBE CHARGED that the American Medical Association had a 'strangle hold' on the practice of medicine, including hospitals, medical schools and even private community agencies. He said that, although the plans of the medical profession, Blue Cross and Blue Shield, had helped bring care to some extent to low income groups, they did not provide adequate coverage."

This quotation from *The Milwaukee Journal* of February 22 is attributed to the director of the Milwaukee County CIO Council's Community Service Committee. It is not a new charge. It has come from many sources—labor, farm, or otherwise. The tragedy of such statements is not alone in their basic falsehood—for anyone might not know the facts—but in their repetition to the point that one can conclude only that there is no attempt to learn the facts or, if they are learned, no effort to report them.

Some groups and individuals are obviously possessed by the strange philosophy that only the "blue collar" class is interested in the common welfare, that humanitarianism is a quality reserved to certain political parties, and that public service is a personal thing incapable of accomplishment by the group, particularly a medical group. It is as if the physician is a Doctor Jekyll-Mr. Hyde, kind and gentle to his patients but conniving and treacherous when conferring with his colleagues.

It is of little avail to refute the remarks quoted in *The Milwaukee Journal*, though it can be done easily and effectively. The speaker would only repeat it tomorrow in a letter, the day after in a bulletin, and the next on TV. Even a well-organized "truth brigade" would be worn out chasing these calculated comments.

One is forced to rely on the public's good common sense and its growing awareness that it cannot believe all that it hears and sees. This approach might be supported by the results of two recent public opinion polls.

The A.M.A.-sponsored poll concluded that most Americans like their own family doctor and like doctors as a group. It also seemed to show that people's opinions gained from their own experiences differ from those based on hearsay or other sources; that doctors are more critical of themselves than are other people; and that when people criticize physicians, it is largely for the cost of care. They do not, however, think doctors are trying to "get rich quick." Only half of the people surveyed said they had any knowledge of the A.M.A.; and of those who did, 43 per cent said their opinion of the A.M.A. was "all good," 26 per cent said it was "more good than bad," 13 per cent "about equal," 4 per cent "more bad than good," and 1 per cent "all bad." Most of these people approved of the strictness of A.M.A. standards for medical schools and hospitals, and neither the public nor doctors surveyed were very critical of the A.M.A.'s political activities.

Closer to home, the *Wisconsin Agriculturist and Farmer* reported in a recent poll that most farmers don't complain too much about doctor fees and seem to feel that the service is generally good. The *Wisconsin Agriculturist* poll summed up the opinions of rural people on doctors:

> "They love and respect and trust their family doctor. Most people feel that fees are not out of line. They would like better service, although they are appreciative of the tremendous job which doctors are doing for them. They would like to train more doctors."

It is probably true that one can lie with polls as well as with statistics. Nevertheless these two opinion surveys give heart to honest men who, knowing that neither they nor all their works are yet perfect, can be given the opportunity to do their best for public health.


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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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The President's Page

THE SECOND QUESTION often asked concerns Social Security, the most discussed question since men quarreled about the relative need for sprinkling or immersion. I refer to a religious analogy, because the security question has such emotional elements that even to doubt its value arouses charges of cold-hearted indifference to human need.

It has won wide acceptance, largely, because of widespread willingness to have someone else furnish the livelihood which might have been self-provided by the very ancient methods of industry and savings, plus not bothering about the Jones' standards.

To answer this question, in addition to my personal views, I am obliged to quote official sources. Social Security is a controversial matter. So far as I can judge, a slight majority of our members oppose. Rather strangely, the older men who would profit most, if there be a profit, are generally opposed. The younger men who have not thought this thing through, are largely in favor. Briefly, the AMA opposes it for the following reasons: (a) Few medical men can ever hope to profit. They do not retire at 65. If they do, they may earn only $900 a year over the security payments. If they wait until 70 or 75, their years are few and they may not hope to regain annual payments previously made. (b) The actuarial basis is unsound. Accumulating yearly deficits finally deplete current income. Social Security strongly resembles the low-cost assessment life companies so numerous about the turn of the century. They paid promptly out of current income until mortality incident to aging of the membership required increasing fees. The youthful membership would not pay higher assessments, leaving the older members with impossible rates. The families of those who died early profited, the living lost everything and had grown too old to take out stronger insurance. I have seen men pay $200 a year on a $1,000 policy, literally hoping they might die. Of course, the present security rates will be raised and, with the help of substantial taxes to meet the costs, the system can live. But another generation must pay their own costs, plus accrued losses, placing a tremendous burden of continuing high taxes on them. As these taxes are not the result of expanding production, the result resembles the boy with torn pants—his end is in sight.

The present probabilities are that we will be included in the system. Our best hope is in the Reed-Keogh bill, which ought to have the earnest political support of every doctor. It is not only a private, but a public duty. Most Indiana Congressmen favor the bill, but you will do yourself a favor if you will take a few moments and invest in a 2c card and tell your Congressman you hope he will support the Reed-Keogh bill.

And since all of them are up for re-election, your card or letter will get real consideration.

W. H. Kennedy

The Woman's Auxiliary

REPORTS TO I.S.M.A.

May, 1956.

It's program planning time! Immediately following the House of Delegates Meeting in Gary, April 26-27, our new Auxiliary year begins.

The last week of March found Mrs. Jerome Holman, Jr., Indianapolis, our capable program chairman, meeting with her committee in the I.S.M.A. office where they discussed plans for the coming year with Mrs. Jeanne Grover and Mr. Jim Waggener. Other committee members who attended were:

Mrs. R. C. Miller of Shelbyville
Mrs. C. A. Jones of Franklin
Mrs. E. W. Mericle of Indianapolis
Mrs. V. J. Vollrath of Indianapolis
Mrs. G. W. Irwin, Jr., of Indianapolis
Mrs. M. O. Scamahorn of Pittsboro

The Auxiliary members are looking forward to a good time working together this coming year, and we hope that the Medical Association will not hesitate to tell us what they would like us to do for them.

Julia Tindall

Mrs. William R. Tindall, President

1956-57 programs and projects of the Woman's Auxiliary to Indiana State Medical Association were in the formative stage when this picture was taken in headquarters office. Left to right: Mrs. V. J. Vollrath; James A. Waggener, executive secretary of ISMA; Mrs. M. O. Scamahorn; Mrs. Earl W. Mericle; Mrs. Jerome E. Holman, Jr., chairman; Mrs. William R. Tindall, Woman's Auxiliary president; Mrs. R. C. Miller; and Mrs. Glenn W. Irwin, Jr. Mrs. C. A. Jones, another committee member, was not present when the picture was taken.



Cesarean Section Rates in Indiana

(A Concluding Study)

HOWARD W. MITCHELL, M.D.*

Indianapolis

AT THE REQUEST of the Maternal and Child Health Committee of the Indiana State Medical Association, a report has been made to the physicians of Indiana on the number of Cesarean sections done in each county by hospital on three previous occasions.[1, 2, 3] The present report brings the study of Cesarean sections up to date. It adds to the already published figures the number of sections and number of live births occurring in the hospitals reporting during 1953 and 1954 and recapitulates the section rates (number of sections per number of live births expressed in percent) for the six years 1949 through 1954.

The primary purpose of this study has been to present the facts to Indiana physicians so that they could determine the variation in rates in different communities of the state and, if they desired, to compare their rates with others and with the state average. In general, Indiana compares favorably with practices elsewhere in this regard.[4]

A secondary purpose was implicit. Should physicians feel it was indicated, they could use these published rates as guidelines in studying their own rates locally and deciding if they wished to review the indications for Cesarean section occurring in their hospitals and in their practices.

During the six-year period there has been a slight downward trend in the over-all state average rate of sections, but not to a significant degree. Most of the changes in rates locally are not of significance statistically and would be expected by chance alone.

In either 1949 or 1954 or both years there were eight hospitals in which the section rates exceeded 10 percent. In five of these there were slight changes in rates, three higher in 1954 than 1949, two lower in 1954 than 1949. None of these changes are significant statistically and could be explained by chance variation. However, in three hospitals there was a marked decrease in rates: from 12.7% to 6.3%; from 18.4% to 5.8%; and from 11.7% to 3.7%. Each of these decreases is significant statistically and could occur by chance only one time in one thousand. It is interesting to note that there was no such significant increase of rates in any hospital from 1949 to 1954.

CONCLUSIONS

In the 104 hospitals in Indiana for which there are complete or partial reports during the six-year period 1949-1954, it can be seen that the Cesarean section rates have remained relatively constant, suggesting that the indications for delivery by Cesarean section have not changed significantly. It is of further interest to note that in 1949 eleven hospitals reported rates over 8% and six over 10%. In 1954 there were only six hospitals reporting rates over 8% and five over 10%. In 1954 there remained one hospital reporting a rate over 15%. There had been two in 1949.

* Director, Division of Maternal and Child Health, Indiana State Board of Health.

[1] Journal of the Indiana State Medical Association, November, 1947.

[2] Journal of the Indiana State Medical Association, September, 1951.

[3] Journal of the Indiana State Medical Association, September, 1954.

[4] Schneider, Bernard, "A Review of Cesarean Section Statistics in a Community and in the United States". American Journal of Obstetrics and Gynecology 68(4), October, 1954, pp. 1082-1090.

TABLE I
CESAREAN SECTIONS 1949-1954

HOSPITAL AND LOCATION	Live Births 1953	Live Births 1954	Cesarean Sections 1953	Cesarean Sections 1954	Percent Sections 1949	1950	1951	1952	1953	1954
TOTALS—INDIANA HOSPITALS	96,758	103,903	3,682	4,067	4.13	4.18	3.92	3.98	3.84	3.91
Adams County										
Decatur										
ADAMS COUNTY MEMORIAL	325	669	15	28	5.91	6.96	5.7	3.2	4.6	4.2
Allen County										
Fort Wayne										
FT. WAYNE METHODIST	1,377	2,056	30	39	2.20	2.24	0.9	1.5*	2.2	1.9
LUTHERAN OF FT. WAYNE	1,998	1,615	48	52	3.15	3.53	2.4	2.5*	2.4	3.2
ST. JOSEPH	2,322	2,183	56	42	1.98	3.03	2.2	2.2	2.4	1.9
Bartholomew County										
Columbus										
BARTHOLOMEW COUNTY	1,036	1,050	35	38	2.77	2.47	2.7	3.5	3.4	3.6
Boone County										
Lebanon										
WITHAM MEMORIAL	718	783	27	20	2.99	3.06	3.5	2.8	3.8	2.6
Blackford County										
Hartford City										
BLACKFORD COUNTY	389	415	13	13	2.14	4.40	3.6	2.9	3.3	3.1
Cass County										
Logansport										
CASS COUNTY MEMORIAL	547	548	26	26	6.97	7.84	6.7	5.6	4.7	4.7
ST. JOSEPH	579	588	14	17	3.09*	3.61	2.0	3.1	2.4	2.9
Clark County										
Jeffersonville										
CLARK COUNTY MEMORIAL	976	956	20	24	5.15*	3.60	3.9	3.7	2.0	2.5
Clay County										
Brazil										
CLAY COUNTY	449	460	21	15	6.64	5.20	4.8	5.2	4.7	3.2
Clinton County										
Frankfort										
CLINTON COUNTY	582	570	26	30	3.11	2.76	3.2	3.8	4.5	5.3
Daviess County										
Washington										
DAVIESS COUNTY	853	806	61	88	9.35	10.52	10.4	5.4	7.1	10.9
Decatur County										
Greensburg										
DECATUR COUNTY MEMORIAL	415	461	19	29	12.65	12.82	10.6	10.1	4.6	6.3
DeKalb County										
Auburn										
DR. SOUDER	No Reps.	145	---	3	1.98	3.19	1.2	2.7*	---	2.1*
SANDERS GENERAL	95	67	4	2	3.05	2.52	2.5*	2.6	4.2*	3.0*
Garrett										
SACRED HEART	415	467	12	20	2.93	3.17	2.6	2.7	2.9	4.3

HOSPITAL AND LOCATION	Live Births 1953	Live Births 1954	Cesarean Sections 1953	Cesarean Sections 1954	Percent Sections 1949	Percent Sections 1950	Percent Sections 1951	Percent Sections 1952	Percent Sections 1953	Percent Sections 1954
Delaware County										
Muncie										
BALL MEMORIAL	2,207	2,574	119	134	3.18	4.35	4.3*	4.8	5.4*	5.2
Dubois County										
Jasper										
MEM. OF DUBOIS COUNTY	466	495	18	32	---	---	5.5*	3.5	3.9	6.5
Huntingburg										
THE STORK	473	485	24	21	6.80	5.37	2.3	5.4	5.0	4.3
Elkhart County										
Elkhart										
ELKHART GENERAL	1,654	1,620	50	53	4.08	3.09	2.9	4.1	3.0	3.3
Goshen										
GOSHEN	730	758	45	57	5.21	7.04	5.5	7.4	6.2	7.5
Fayette County										
Connersville										
FAYETTE MEMORIAL	706	703	37	46	3.02	4.15	4.7	4.3	5.2	6.5
Floyd County										
New Albany										
ST. EDWARD	1,285	722	58	33	4.68	4.48	4.6	4.6	4.5	4.6
Fulton County										
Rochester										
WOODLAWN	421	437	42	49	12.60	12.20	11.9	12.1	10.0	11.2
Gibson County										
Princeton										
GIBSON GENERAL	505	520	2	8	1.86	1.39	1.4	0.2	0.39	1.5
Oakland City										
OAKLAND CITY WOOD	144	145	0	2	---	---	1.6	---	---	1.4
Grant County										
Marion										
MARION GENERAL	1,390	1,565	75	78	3.13	4.06	4.3	3.8	5.4	5.0
Greene County										
Linton										
FREEMAN-GREENE CO.	519	542	82	102	19.39	18.02	16.7	14.9	15.8	18.8
Hamilton County										
Noblesville										
HAMILTON COUNTY	582	---	40	---	6.95*	9.11	6.8*	5.8	6.9	---
Hancock County										
Greenfield										
HANCOCK CO. MEM. (new)	440	487	17	20	---	---	---	4.1	3.9	4.1
Harrison County										
Corydon										
HARRISON COUNTY	348	367	7	4	---	3.73*	2.1	1.5	2.0	1.1
Henry County										
New Castle										
HENRY COUNTY	1,309	1,288	47	38	4.05	4.46	4.0*	3.3*	3.6	2.9
Howard County										
Kokomo										
ST. JOSEPH	1,402	1,500	58	65	3.71	3.71	3.3	3.3	4.1	4.3
Huntington County										
Huntington										
HUNTINGTON COUNTY	674	752	9	18	1.44*	1.32	1.6	1.1	1.3	2.4

HOSPITAL AND LOCATION	Live Births 1953	Live Births 1954	Cesarean Sections 1953	Cesarean Sections 1954	Percent Sections 1949	Percent Sections 1950	Percent Sections 1951	Percent Sections 1952	Percent Sections 1953	Percent Sections 1954
Jackson County										
Seymour										
JACKSON CO. SCHNECK MEMORIAL	984	1,012	41	46	4.95	4.66	6.1	4.8	4.2	4.5
Jasper County										
Rensselaer										
JASPER COUNTY	478	507	21	20	6.82	6.01	6.5	6.1	4.4	3.9
Jay County										
Portland										
JAY COUNTY	478	546	44	32	18.38	16.70	13.4	9.3	9.2	5.8
Jefferson County										
Madison										
KING'S DAUGHTERS	697	746	25	25	4.62	6.12	4.6	3.5	3.6	3.4
Johnson County										
Franklin										
JOHNSON CO. MEM.	757	798	20	19	2.53	1.22	2.3	2.1	2.6	2.4
Knox County										
Vincennes										
GOOD SAMARITAN	979	917	53	54	3.83	3.74	4.2	4.8	5.4	5.9
Kosciusko County										
Warsaw										
McDONALD	335	358	6	15	2.06	1.44	4.6	2.2*	1.8	4.2
MURPHY MED. CENTER	244	251	15	15	6.15	7.00	5.6	3.3	6.1	6.0
LaGrange County										
LaGrange										
LaGRANGE COUNTY	447	466	15	16	---	8.33	2.7	2.7	3.3	3.4
Lake County										
East Chicago										
ST. CATHERINE	2,303	2,389	81	62	3.19	3.31	3.9	3.8	3.5	2.6
Gary										
METHODIST OF GARY, INC.	3,688	4,029	101	131	2.59	2.95	2.9	2.8	2.7	3.2
ST. MARY'S MERCY	2,654	2,977	68	56	2.56	2.28	2.9	2.7	2.6	1.9
Hammond										
ST. MARGARET	3,367	3,866	131	135	2.73	3.40	3.7	3.7	3.9	3.5
LaPorte County										
LaPorte										
FAIRVIEW	583	646	45	53	8.73	8.24	7.1	6.9	7.7*	8.2
HOLY FAMILY	509	482	34	26	3.21	5.72	5.3	5.6	6.7	5.4
Michigan City										
DOCTORS' HOSPITAL	312	377	14	14	11.70	13.86*	2.8*	0.0*	4.5	3.7
ST. ANTHONY	873	871	23	30	4.06	3.50	3.3	3.4	2.6	3.4
Lawrence County										
Bedford										
DUNN MEMORIAL	922	1,017	48	49	5.78	5.42	4.6	7.1	5.2	4.8
Madison County										
Anderson										
ST. JOHN'S HICKEY MEM.	2,156	2,144	140	117	9.12	9.66	5.0	6.1	6.5	5.5
Elwood										
MERCY	491	509	8	9	1.76	1.94	2.5	1.6	1.6	1.8

HOSPITAL AND LOCATION	Live Births 1953	Live Births 1954	Cesarean Sections 1953	Cesarean Sections 1954	Percent Sections 1949	1950	1951	1952	1953	1954
Marion County										
Beech Grove										
ST. FRANCIS	2,766	3,123	45	46	1.27	0.83	1.3	1.3	1.6	1.5
Indianapolis										
INDIANAPOLIS GENERAL	1,780	2,229	42	52	3.14	3.10	2.9	2.6	2.3	2.3
I.U. MEDICAL CENTER	2,828	2,936	135	167	5.67	6.33	5.8	5.1	4.8	5.7
METHODIST	6,287	6,407	260	210	5.01	3.95	4.2	4.7	4.1	3.3
ST. ELIZ. MATERNITY	39	51	0	0	0.00	0.00	0.0	0.0	0.0	0.0
ST. VINCENT'S	No Reps.	2,289	---	61	3.37*	3.19*	3.0	3.5*	---	2.7
Marshall County										
Argos										
KELLY										
Bremen										
COMMUNITY	213	272	2	0	0.00*	0.00*	0.0	0.0	0.94	0.0
Plymouth										
PARKVIEW	474	347	25	14	1.80	2.33*	3.0	4.7*	5.3	4.0*
Miami County										
Peru										
DUKES-MIAMI COUNTY	638	606	33	13	3.50*	6.30*	4.0*	3.4	5.2	2.1
Monroe County										
Bloomington										
BLOOMINGTON	1,256	1,322	73	72	5.57	5.98	6.0	6.3	5.8	5.4
Montgomery County										
Crawfordsville										
MONT. CO. CULVER UNION	846	859	21	32	3.73	3.69	3.1	2.3	2.5	3.7
Morgan County										
Martinsville										
MORGAN COUNTY MEMORIAL	379	352	6	12	0.33*	0.82	0.8	0.7	1.6	2.6
Noble County										
Kendallville										
McCRAY MEMORIAL	378	402	22	43	8.68	7.79	9.3	7.5	5.8	10.7
Wolflake										
LUCKEY	96	157	6	8	1.81	2.78	0.7*	7.7	6.2*	5.1
Orange County										
Paoli										
CLARK	No Reps.									
Perry County										
Tell City										
PARKVIEW	---	---	---	---	0.51	0.00*	---	---	---	---
PERRY COUNTY	416	400	4	8	---	0.00*	1.7	1.1	.96	2.0
Porter County										
Valparaiso										
PORTER MEMORIAL	843	852	21	36	3.45	2.96	2.5	3.8	2.5	4.2
Pulaski County										
Winamac										
CARNEAL'S PRIVATE	131	153	2	1	0.00	1.57*	2.2	0.0	1.5*	.65

HOSPITAL AND LOCATION	Live Births 1953	Live Births 1954	Cesarean Sections 1953	Cesarean Sections 1954	Percent Sections 1949	Percent Sections 1950	Percent Sections 1951	Percent Sections 1952	Percent Sections 1953	Percent Sections 1954
Putnam County										
Greencastle										
PUTNAM COUNTY	528	564	18	27	3.61	2.95	3.7	4.9	3.4	4.8
Randolph County										
Union City										
UNION CITY MEMORIAL	202	218	21	29	11.38	10.78*	9.8	9.9	10.4	13.3
Winchester										
RANDOLPH COUNTY	440	507	27	34	8.57	12.39*	8.3*	9.2*	6.1	6.7
Ripley County										
Batesville										
MARGARET MARY	768	846	13	19	1.79	1.51	2.2	1.7	1.7	2.2
Milan										
WHITLATCH CLINIC	212	360	9	9	2.81	2.32	2.2	5.7	4.2*	2.5
Rush County										
Rushville										
RUSH MEMORIAL	492	568	14	29	---	3.17	2.6	1.9	2.8	5.1
RUSHVILLE CITY	---	---	---	---	2.76*	---	---	---	---	---
St. Joseph County										
Mishawaka										
ST. JOSEPH	1,240	1,123	19	25	2.29	1.87	1.7*	1.3	1.5	2.2
South Bend										
MEM. OF SOUTH BEND	2,533	2,369	111	119	7.35*	5.84*	5.3	4.9	4.4	5.0
ST. JOSEPH	2,065	1,947	57	67	2.95	3.70	3.7	2.8	2.8	3.4
SO. BEND OSTEOPATHIC	687	790	10	21	3.61*	3.31	3.4	3.2	1.5	2.7
Scott County										
Scottsburg										
NAPPER	---	---	---	---	0.00	0.00*	2.4*	0.0	---	---
Shelby County										
Shelbyville										
WILLIAM S. MAJOR	615	706	10	19	3.23	3.33	3.3*	3.7	1.6	2.7
Starke County										
Knox										
STARKE CO. MEM. (new)	450	503	10	30	---	---	---	4.9	2.2	5.9
Steuben County										
Angola										
CAMERON	176	196	2	9	3.74	4.88	1.4*	1.4	1.1*	4.6*
ELMHURST	186	227	3	6	0.54	2.52	2.7	1.4	1.6	2.6
Sullivan County										
Sullivan										
MARY SHERMAN	471	558	7	12	1.54	1.98	2.6	2.5	1.5	2.2
Tippecanoe County										
Lafayette										
LAFAYETTE HOME	1,348	1,478	75	92	4.30	4.56	4.7	6.3	5.6	6.2
ST. ELIZABETH	1,372	1,405	49	63	3.16	2.68	3.1	2.8	3.6	4.5
Tipton County										
Tipton										
BURKHART EMERGENCY	No Reps.									
TIPTON CO. MEM.	---	430	---	27	---	0.00*	2.8*	7.3	---	6.3

HOSPITAL AND LOCATION	Live Births 1953	Live Births 1954	Cesarean Sections 1953	Cesarean Sections 1954	Percent Sections 1949	Percent Sections 1950	Percent Sections 1951	Percent Sections 1952	Percent Sections 1953	Percent Sections 1954
Vanderburgh County										
Evansville										
PROTESTANT DEACONESS	2,790	3,081	57	88	2.37*	3.05*	3.0	2.2	2.0	2.9
ST. MARY'S	1,389	1,303	44	34	2.91	2.27	1.8	2.9	3.2	2.6
WELBORN MEM. BAPTIST	930	1,000	48	46	7.17	4.77	4.4	5.1	5.2	4.6
Vermillion County										
Clinton										
VERMILLION COUNTY	553	542	46	30	6.84	4.34	5.1	6.1	8.3	5.5
Vigo County										
Terre Haute										
FLORENCE CRITTENDON HOME	No Reps.									
HOOVER SANATORIUM	21	45	0	0	3.28*	0.00*	0.00*	7.7*	.0*	.0
ST. ANTHONY	1,201	1,103	20	26	2.02	2.05	1.9	1.3*	1.7	2.4
UNION	1,395	1,549	61	59	3.49	6.19	4.4	5.1	4.4	3.8
Wabash County										
Wabash										
WABASH COUNTY	588	601	43	43	6.28	8.15	7.9	8.1	7.3	7.1
Warren County										
Williamsport										
COMMUNITY	187	175	10	8	0.00	0.00*	5.1*	3.4	5.3	4.6
Washington County										
Salem										
WASH. CO. MEM.	343	522	15	25	---	7.14*	4.1	5.7	4.4*	4.8
Wayne County										
Richmond										
REID MEMORIAL	1,761	1,779	70	81	4.85	2.96	4.2	4.9	4.0	4.6
Wells County										
Bluffton										
CLINIC	146	189	3	5	2.70	6.70*	3.0*	0.7	2.0	2.6
WELLS COUNTY	327	326	7	16	3.80	3.53	4.3	3.5	2.1	4.9
Whitley County										
Columbia City										
WHITLEY CO. MEMORIAL	374	429	16	24	---	---	2.6*	4.7*	4.3*	5.6

* Estimated from incomplete returns.

Notes on the Diagnosis and Management of "Dizziness"

III. Ménière's Syndrome





1. Paroxysmal Whirling Vertigo. *This consists of sudden attacks of dizziness, often when the patient is at rest or asleep. The patient may feel that he himself is whirling or that fixed objects about him are whirling. The attack usually lasts for a few minutes; occasionally it is severe for weeks or subacute for months.*



2. Subtotal Hearing Loss. *Deafness will usually affect the high tones and it may be unilateral or bilateral. Sometimes the hearing loss is severe and also progressive.*

3. Tinnitus. *This is usually unilateral and present in the ear with greater hearing loss and is without a definite pattern.*



Fewer diagnostic errors[1] will result if a "triad of symptoms" is required of patients with suspected Ménière's syndrome. These are the symptoms of typical Ménière's syndrome:

1. Severe paroxysmal vertigo which may be of two types; either the patient feels that he is whirling or that objects about him are whirling.
2. Fluctuating subtotal hearing loss, usually affecting the higher tones, is noted at the same time as vertigo.
3. Tinnitus, usually unilateral, is associated with the deafness and dizziness.

With Ménière's syndrome there is no definite localization[2] by the Bárány (vestibular reaction) test and results of the caloric test are not diagnostic. Physical examination should rule out disease of the central nervous or cardiovascular systems before a diagnosis is made.

"Treatment with Dramamine®. . . is effective[3] in aborting and preventing attacks of Ménière's syndrome . . . will prevent or arrest attacks of vertigo. It will also reduce the intensity of the tinnitus and so may save some of the hearing in the affected ear."

Dramamine is recommended for Ménière's syndrome as the sole therapy or in combination with other treatment programs.

It is a therapeutic standard also for motion sickness and is useful for relief of nausea and vomiting of radiation sickness and fenestration procedures.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.); Supposicones® (100 mg.); ampuls (250 mg.); liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

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Report on the First Annual Camp for Diabetic Children in Indiana

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PURPOSE: Discussion of the first annual camp for diabetic children from a medical standpoint.

The need of a camp for diabetic children in the state of Indiana has long been recognized. Under the sponsorship of the Lay Society and the Medical Society of the Indianapolis Diabetic Association, the James Whitcomb Riley Camp for diabetic children was opened on June 26, 1955.

The Physical Facilities: The physical facilities of the camp are built on part of the 2,300 acre Bradford estate that was willed to Indiana University. The intent of the will was that the land be used for educational purposes with particular regard to handicapped children. Indiana University and the Riley Foundation prepared a camp site on top of the highest hill of the area. The buildings consist of a combination dining hall and craft shop, infirmary, and tents. The dining hall will seat approximately 100 persons. The food preparation area is directly adjoining the dining hall. It is modern and adequate to serve large numbers. The ground floor of this building is equipped with facilities for the craft shop. The infirmary is a seven room structure designed specifically for both out-patient and temporary in-patient use, and as a living area for the resident medical staff. It has an admitting room with two lavatories directly adjoining it. It has the added facilities of a well-equipped laboratory for doing complete urinalysis, complete blood counts, and blood sugars. The campers' sleeping quarters are tents with wood floors and are screened. Two areas of five tents each are located at opposite ends of the camp site. The terrain of the camp is hilly and covered with fine trees. A small stream is within 15 minutes hiking of the dining hall and provides a place for the campers to wade.

The Campers: The campers were diabetic children from the state of Indiana. Ages were limited to 8-15 years and there were 12 girls and 14 boys. Applications were received through the campers' physicians and selection was made in the order received. The fee was $200 per camper for the month of camp. No camper was accepted for any shorter length of time.

Camp Personnel: The camp had two directors, one in charge of camping activities, and a physician in charge of the medical routine. The camping personnel consisted of four male and four female counselors, all of whom were either college students or school teachers. The dietary staff consisted of a trained hospital dietician from Indianapolis Methodist Hospital, an assistant dietician, two cooks, and two kitchen helpers. The resident medical staff consisted of a medical resident from Indiana University Medical Center, a senior medical student, one or two registered nurses trained in diabetic work, two student nurses, and a registered laboratory technician. In addition to the resident medical staff a visiting physician from Indianapolis came each day.

Medical Routine: In general, the activities concerned with camping were considered most important. The medical department was run in such a manner that the children could enjoy

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these activities with a minimum of medical interference.

Prior to admission, on the basis of application forms filled out by the local physicians, the starting diet and insulin dose were decided upon by the medical director and his committee. On admission, a brief present and past medical history was obtained from each camper and his parents. A physical examination and urinalysis were done. Each camper had a diabetic chart and infirmary record. Each morning all campers would come to the infirmary upon arising to collect a urine specimen and receive their insulin dose. After receiving their insulin, each camper was given a chip, the color of which indicated the size of the diet they would receive at the dining hall. The three different diets were weighed and placed on plates whose color corresponded to that of the chip. The diet quotations were: No. 1 diet was 150 gms. carbohydrate, 100 gms. protein, and 100 gms. fat; No. 2 diet was 200-110-125; No. 3 diet was 250-115-150. Between meal and evening feedings were given and adjusted to correlate with the severity of the activities.

Sick call was held after breakfast for those who had any medical complaints. The medical staff posted a list of those they wishel to see and each counselor was responsible for sending them to the infirmary. Blood sugars were run on every camper within the first three days of camp. The times of day were 6:30 a.m., 11:00 a.m., 4:30 p.m., and 8:30 p.m. A urine sugar was run on every child each morning and if a camper was spilling sugar, this was repeated at 11:00 a.m., 4:00 p.m., and possibly 8:30 p.m. We used the urine sugar as a guide for the need of a blood sugar and both as an aid in the adjustment of insulin dosage. Insulin doses were considered every day by the camp physicians after the blood and urine sugars determinations were completed. Night rounds were made at 11:00 p.m. each night. Several times orange juice was given as a precautionary measure rather than because of any frank sign of reaction. For the first week, 3:00 a.m. rounds were made, but no reactions were encountered, so these were discontinued.

The counselors always carried orange juice to administer in case of reactions. Emergency kits were prepared containing two 10 cc ampules of 50% glucose, two 10 cc syringes, a file, tourniquet, cotton, alcohol, and two 20-gauge needles. One of these was kept in the dining hall and the other was used on night rounds.

Medical Records: It was noted that several campers requested an increase in their diet which was granted. At the end of camp we had 7 campers on a No. 1 diet, 12 on a No. 2 diet and 7 on a No. 3 diet. The referring physicians of 25 of the campers reported that their patients were instructed to follow a known diet qualitatively and quantitatively. One child was on a free diet. It was interesting to note that under controlled camp conditions, this camper had the greatest weight gain—eight pounds. The average total carbohydrate intake per camper on admission was 202 gm. per day according to their physicians' reports. The average total carbohydrate intake at camp was 315 gm. per day.

The average insulin dose on admission to camp was found to be greater than the need in consideration of the increased activity and a well-controlled diet. We found, as a general rule, that it was necessary to cut every camper's insulin dose the second and third day of camp. We noted that the insulin needs decreased the first week of camp and then it was necessary to raise the insulin dose slightly the second week. The third week we had to cut the dose sharply and then gradually raise the dose to maintain a relatively physiological blood sugar. The campers were on all types of insulin on admission and these were not changed. All but one noon dose was eliminated, as well as many evening doses. However, in several instances, it was necessary to restart the evening dose, as they would have morning glycosuria and acetonuria. It was found on averaging the insulin dose change from the admission dose to the eighth day that an average reduction of insulin of two units per day per camper was necessary. On the fifteenth day, the average reduction was 1.1 unit per camper. On the twenty-second day, an average reduction of 9 units per camper, and the twenty-eighth day the insulin requirements were 7 units less on the average per camper per day than the admission dose. This is only the average and shows the general trend. However, it is well known that each diabetic must be considered individually in regard to his insulin needs.

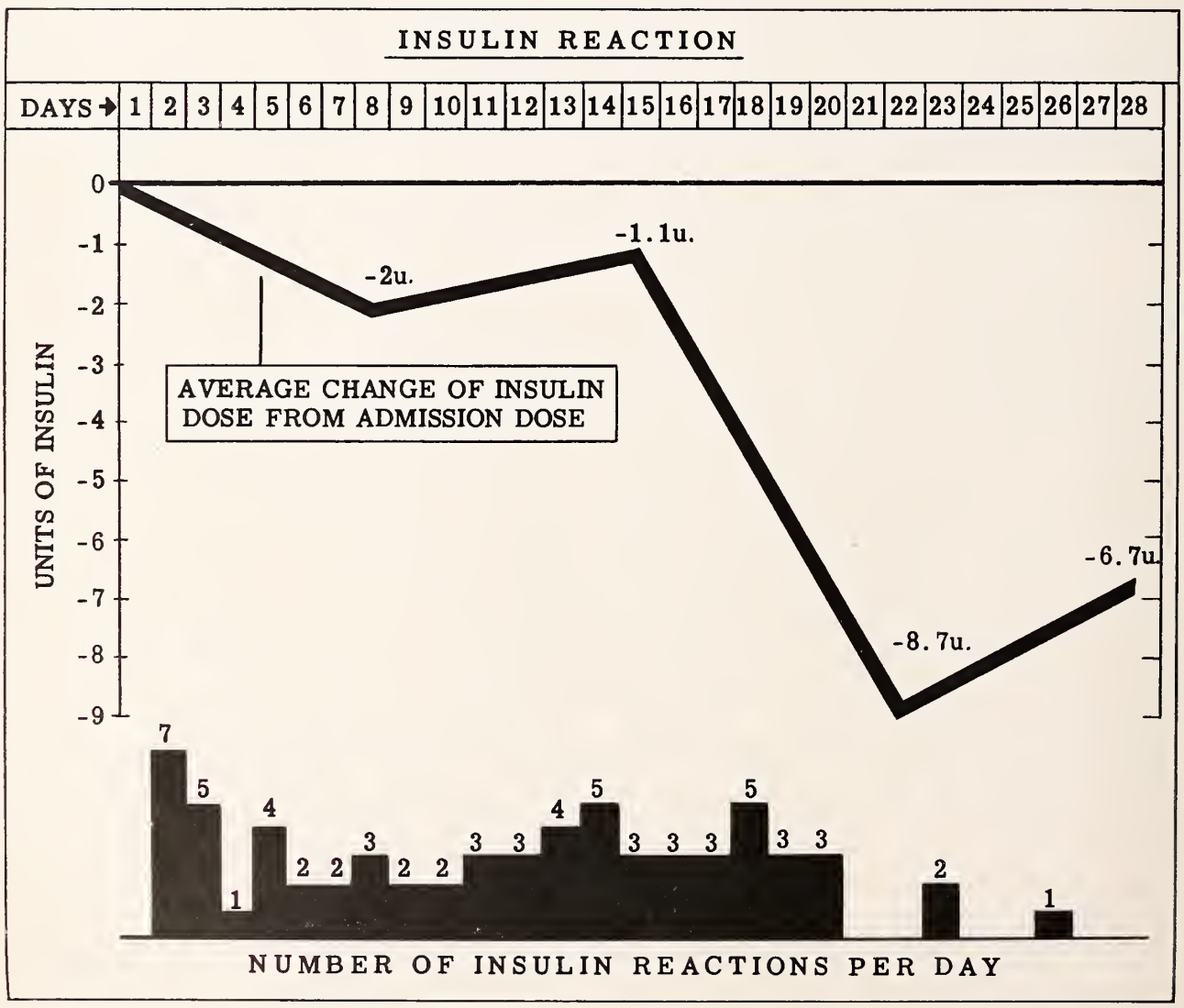
We had a total of 66 insulin reactions for 728 camper days. All of the reported insulin reactions were not confirmed by the medical staff, as each counselor carried orange juice to be ad-

ministered as needed. Most of the reactions occurred just prior to meal time with 26 occurring from 10:00 a.m. to 1:00 p.m. There were 47 reactions in the girls and 22 reactions in the boys. There were 6 cases where it was felt wise to give intravenous glucose. All campers responded quickly to treatment with no detectable morbidity. All reactions of the first three weeks of camp were recorded and compared with the activities in which the campers participated. No correlation in regard to the distance hiked or the type of activity was found. This did not consider the most important variable, that of individual activity. Only one mild reaction occurred while the campers were away from camp on hikes. This may be accounted for by the planning of strenuous activities only after meals or mid-day feedings.

The laboratory technician ran a total of 954 urine sugars for a daily average of 34 tests. Using Lilly's Testape, these were quite simple. Two hundred and twenty-two blood sugars were run for a daily average of eight.

Every third day each camper was weighed and the results were plotted on a scatter-graph. The mean change in weight from admission over the four week period revealed 1.7 pound gain per boy and 1.5 pound gain per girl.

At no time was acidosis or impending acidosis detected in any of the campers. No major medical problems were presented by the campers. We saw and treated a few cases of otitis externa and upper respiratory infections. Many campers had poison ivy but the cases were surprisingly mild. There were few cases of homesickness and these were treated by the medical staff with sympathy and suggested increased activity and participation in camp life. A short discussion period on diabetes and its problems was held for each age group. We made an effort to educate each child in regard to administration of his own insulin. It was surprising and gratifying to find out the



Routine Immunization of Children

LYMAN T. MEIKS, M.D.

Indianapolis

IT IS GENERALLY ACCEPTED that all infants should be given inoculations to provide active immunity against diphtheria, tetanus, pertussis and smallpox.

Although there are minor acceptable variations in the timing and type of preparation used, it is common practice to use the mixture of antigens against diphtheria, tetanus and pertussis, given as a single inoculation intramuscularly, beginning at the age of three months and continuing for a total of three injections at intervals of approximately one month. Most preparations available are given in doses of 0.5 cc. each time. Because of their superior immunizing property, the slow acting preparations combined with alum or aluminum hydroxide are preferred. If the outside of the needle is not coated with the antigen and if the injection is given at least one-half inch beneath the skin, the occurrence of "sterile abscesses" will be minimized. A "booster shot" at about one year of age of the same preparation is desirable. Beyond the age of one year a further booster of pertussis vaccine is usually not necessary, but it is good to boost with tetanus and diphtheria toxoid at about two year intervals. In older children the local reaction to alum or aluminum hydroxide toxoid is occasionally severe, so that with them the fluid preparations are to be preferred.

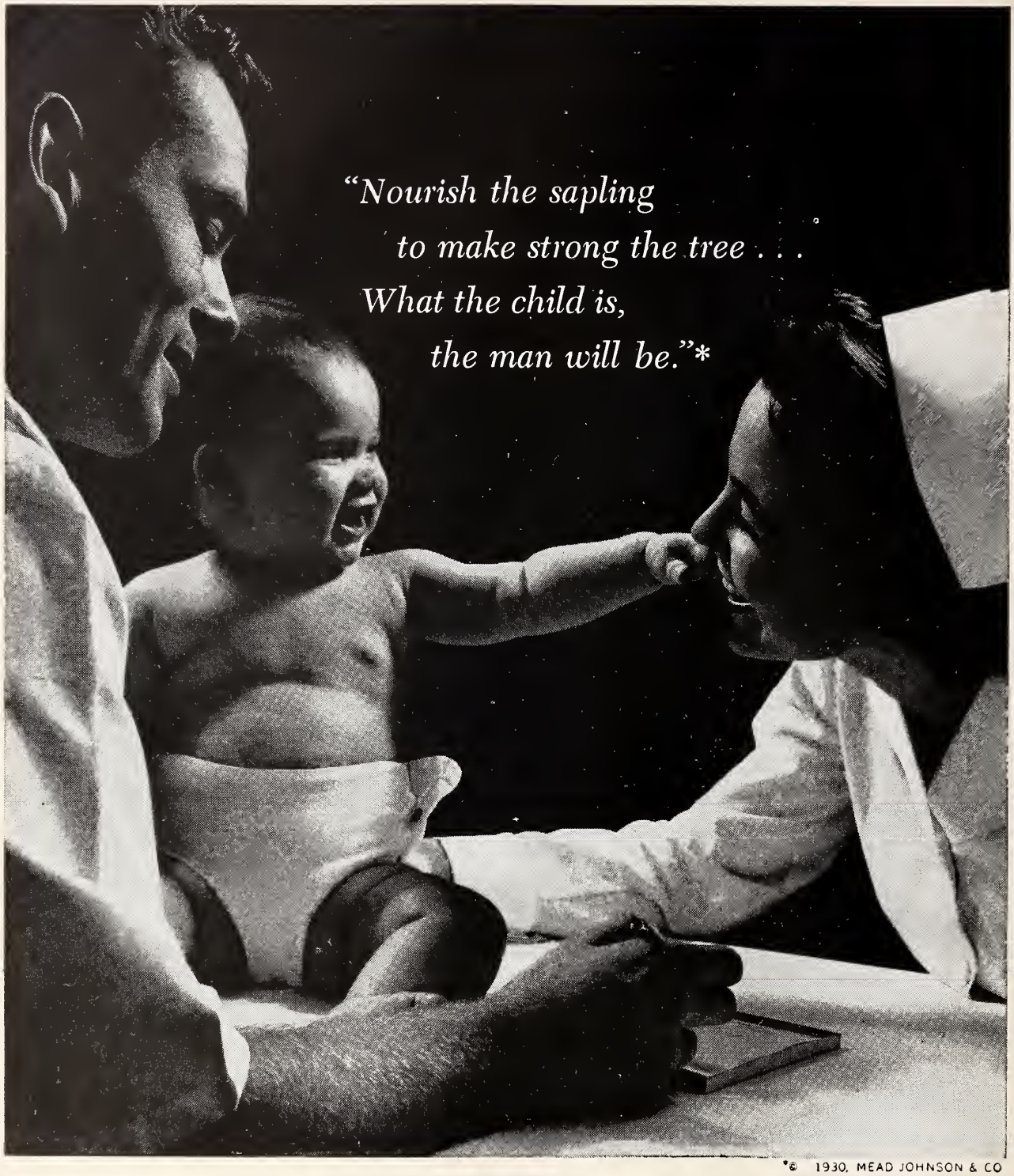
The initial smallpox vaccination is best given during the second six months of life. The only real contraindication is the presence of a moist skin lesion such as eczema. Revaccination for smallpox after the initial "take" should be done about every five years.

Report on First Annual Camp (Continued)

extent of each child's knowledge on the subject of his condition.

Discussion: We feel that this first camp in the state of Indiana for diabetic children was successful on the basis of excellent pre-camp planning and close cooperation between the camp dietary, medical, and counseling staffs. As is well known, children present problems in the management of their diabetes not usually found in adults. We feel that this increased lability of their diabetes was adequately managed by the excellent facilities available. The advantage of having a well educated counseling staff contributed greatly to the success of the camp and to the management of the diabetes and prevention of severe reactions. We do not feel that the number of reactions was too great when the extremes of exercise and activity of children is considered.

Summary: This has been the medical report of the first diabetic camp for children in Indiana. The camp facilities, personnel, medical routine, and the results have been presented. The plans for the next camp are already completed and this will open at the same site for one month beginning June 17, 1956. The size of the camp will be increased to 40 campers and the age limit increased to 16. It is felt that the medical facilities are adequate to take care of this increased number.



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Although the recommended daily allowance of one gram of protein per kilogram of body weight is adequate for the average healthy adult,[1] greater amounts may be needed in the rehabilitation of patients depleted in protein after severe infections, mechanical trauma, burns, or extensive surgery.[2] Protein needs for tissue regeneration during convalescence are high.

To speed rehabilitation of the protein depleted patient, top quality protein and calories should be given in generous quantity.[2] However, a high protein intake, 130 grams daily, at best induces a slow response.[3] Intakes at 3 or 4 times that level may produce considerably more rapid gain in weight, strength, and morale.[4,5] If mastication and swallowing are difficult, canned strained meats—such as used in infant feeding—may be used to advantage in the high protein diet.[2]

Lean meat, outstanding in contained top quality protein, may well be made the keystone of the high protein diet. Its abundance of vitamin B complex and essential minerals—iron, phosphorus, potassium, and magnesium—adds to its therapeutic value. Important also are its appetite appeal, its easy digestibility, and its virtual freedom from allergenic properties.

1. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953.
2. Co Tui: Review: The Fundamentals of Clinical Proteinology, J. Clin. Nutrition *1*:232 (Mar.-Apr.) 1953.
3. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, Univ. of Minnesota Press, 1950.
4. Burger, G.C.E.; Drummond, J.C., and Sandstead, H.R.: Malnutrition and Starvation in Western Netherlands, The Hague General State Printing Office, 1948, Part II, p. 91.
5. Co Tui; Kuo, N.H.; Chuachiaco, M., and Mulholland, J.H.: The Protein Depletion (Hypoproteinia) Syndrome and Its Response to Hyper-Proteinization, Anesth. & Analg. *28*:1 (Jan.-Feb.) 1949.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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A.M.A. Plans Civil Defense Meeting Preceding Annual Convention in June

THE NATIONAL Medical Civil Defense Conference, sponsored annually by AMA's Council on National Defense, will be held Saturday, June 9, at Chicago's Palmer House, just prior to the opening of the 105th Annual Meeting.

Although final arrangements have not been completed, the Council reports that a special feature of this year's program concerns the availability and operation of the Federal Civil Defense Administration's 200-bed emergency civil defense hospital. FCDA officials will discuss basic plans dealing with the allocation, distribution and utilization of the hospital units. Staffing patterns and actual operating procedures by professional and other personnel will be discussed on the basis of data gleaned during field tests conducted in April by the Army Medical Corps at Fort Meade, Maryland, in which representatives of national health and medical organizations participated.

Also on the program will be appropriate films on technical medical subjects related to civil defense and presentations by outstanding authorities in the field.

The one-day session will be attended by representatives of local, state and national civil defense committees, physicians and other leaders of health and medical care facilities. Physicians planning to attend AMA's Annual Meeting are urged to come a day or two earlier to attend this valuable civil defense meeting. Further information may be obtained from the Council on National Defense.

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What Americans Think of the Medical Profession: Report of a Survey

Results of a public opinion poll made for the American Medical Association by an independent research firm are being published in a series of articles. This is the third instalment and deals with VIEWS ABOUT ORGANIZED MEDICINE.

SUMMARY 2—PART I

THE AMERICAN MEDICAL Association, official "voice of the medical profession," has for a number of years occupied a somewhat controversial position on the American scene. It is as often hailed as it is harpooned for its programs and policies. Any organization which receives so much attention in the public press—both favorable and unfavorable—runs the risk of being stereotyped by the public. Once a mental stereotype of a group of individuals or an organization is created in the public's minds, all of its actions are viewed within the frame of reference of that preconceived image. When such stereotypes exist, efforts to reach the public with a specific message or to reduce misunderstandings become much more difficult.

Many doctors seem to think that the public does not look as kindly upon organized medicine as it might. Conversely, some of the Association's critics hold the opinion that doctors themselves are not strong supporters of the A.M.A. What kind of impressions do people have about A.M.A.? What do doctors think of A.M.A.? Are these opinions favorable or unfavorable? And, how do physicians and the public view some of the policy stands of the A.M.A.? The answers to these and similar questions are contained in the summary of the recent public opinion survey.

Knowledge of A.M.A. is not as widespread as might be expected. Only half of the people say they know about it. In answer to an introductory question, 48% of the general public say they have seen or heard or read something about the American Medical Association. Only about a fifth (19%) of those who know A.M.A. recall anything specific about it. Even lower proportions of those in the lower income groups and those with less education say they know A.M.A. Knowledge of A.M.A. is also lower in union member families (43%) than in non-union families (50%).

People's chief recollections are of general publicity, drug researches, professional standards, conventions and opposition to government medicine. About a fourth (26%) of the people who know A.M.A. say public information, radio and television and health articles are the things they remember about the Association. Fourteen percent mention investigation of drugs and treatments; 11 percent, professional standards; 8 percent, opposition to government medicine; and 8 percent, meetings and conventions. Small percentages (less than 5% in each case) mention research; regulation of the profession, schools and hospitals; postgraduate education; public protection, and professional activities. Only 2 percent say it is a doctors' union or medical trust, and a similar number mention its political and lobbying activities.

People who know of A.M.A. have predominantly favorable impressions—about the same as their impressions of the dental associations and better than their impressions of the bar association. Of the people who know A.M.A. 43% have favorable impressions of it. Another 26% say their impressions are more good than bad and 13% say they are about equal. Only 5% say bad impressions outweigh good ones.

Similar questions were asked about the Ameri-

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can Dental Association and the American Bar Association. Replies show almost identical appraisals of A.M.A. and the dental association. Public impressions of the bar association are less favorable than impressions of either A.M.A. or A.D.A.

(People not familiar with an association or who express no opinion are excluded and the reduced base is used here as 100%.)

	Public's impressions of—		
	A.M.A.	A.D.A.	A.B.A.
All good	49%	48%	33%
More good than bad	30	31	33
About equal	14	17	26
More bad than good	5	3	7
All bad	2	1	1

Among those who know of the A.M.A. the highest proportion having more unfavorable than favorable impressions are the people who dislike most doctors as contrasted to only one-twentieth of the general public who have unfavorable impressions. People who dislike most doctors and those who dislike A.M.A. also have the most unfavorable impressions of the American Bar Association (13%, 22%) and of the American Dental Association (6%, 9%).

It is interesting to note that those people who know A.M.A. have far better impressions than editors and commentators, 24% of whom say their impressions are bad. Their criticism of the Association indicates they are not voicing the opinions of the general public about it.

Most doctors have good impressions of A.M.A., yet doctors themselves give the A.D.A. higher ratings than they do the A.M.A. Almost three-fourths (73%) of the doctors say their impressions of the A.M.A. are good. One doctor in twelve (8%) has negative impressions of the Association, while 11% are critical of the Bar Association and only 2% are critical of the Dental Association. Only 7% of the member doctors as against 10% of the non-members are critical of A.M.A.

4 out of 5 laymen who know AMA ★ think well of it



2/3 of them think well of ABA ★



★ LAYMEN'S OPINION OF ASSOCIATIONS:

	ALL GOOD	MORE GOOD THAN BAD
American MEDICAL Association	49%	30%
American DENTAL Association	48%	31%
American BAR Association	33%	33%

Nearly 3/4 of doctors think well of AMA ★



Nearly 5/6 of them think well of ADA ★



...while 6 in 10 of these doctors think well of ABA ★



★ DOCTORS' OPINIONS OF ASSOCIATIONS:

	ALL GOOD	MORE GOOD THAN BAD
American MEDICAL Association	24%	49%
American DENTAL Association	37%	45%
American BAR Association	27%	43%

	Doctors' impressions of—		
	A.M.A.	A.D.A.	A.B.A.
All good	24%	37%	27%
More good than bad	49	45	43
About equal	19	16	19
More bad than good	7	2	8
All bad	1	—	3
(No opinion)	2	43	41

People ascribe much more laudable purposes to the A.M.A., such as improving standards and keeping the profession informed, than doctors expect them to. Doctors' answers to, "What do you think the general public sees as the main purposes of the A.M.A.?" reveal that they think the public has many unfavorable ideas about the Association. A fourth of the doctors (24%) say the public looks upon A.M.A. as a doctors' union and medical trust, yet the same survey revealed only 3% of the public has this opinion. Others mention such concepts as lobbying; politics; public relations; fighting government medicine; policing the profession, schools and hospitals; improving medical standards; research; recommending drugs and treatment and so forth.

But the people themselves mostly think of the A.M.A. as promoting better medical standards,



WHAT LAYMEN THINK AMA IS FOR—

Chief opinions:

say	
27%	improve profession
22%	to inform doctors
16%	for research, reporting (drugs, etc.)
15%	to police profession, hospitals, schools
10%	to serve, protect public



WHAT DOCTORS SAY AMA IS FOR—

Chief opinions:

say	
44%	for public information, relations
28%	to influence legislation
27%	to improve medical care
15%	to improve profession
9%	for research, reporting (drugs, etc.)

informing doctors, and investigating drugs and regulating medical care.

"What would you say are the main purposes of the A.M.A.?"

(Asked of the public)

	People who know A.M.A.	Total public
Improving profession, higher standards	27%	13%
Informing doctors, exchanging ideas	22	11
Research, recommending drugs, treatments	16	8
Policing profession, schools, hospitals	15	7
Serving, protecting public	10	5
Serving, protecting doctors	8	4
Public relations, voice of profession	8	4
Improving public health	4	2
Doctors' union, medical trust	3	1
Setting fees	2	1
Lobbying, politics	1	1
Other mentions	6	3
Don't know	14	7
Don't know A.M.A.	--	52

Doctors' own ideas are that public relations, legislative interest and improving medical care are its main aims for the public; and that promoting professional standards, keeping them informed and public relations are its main aims for the doctors. Almost all aims of the A.M.A. for the public are positive, according to doctors. They also say its aims for the doctors are similar to its aims for the public.

"What would you say are the main aims of the A.M.A.?"

(Asked of doctors)

	For public	For doctors
Public information, public relations	44%	19% (PR only)
Legislative interest and lobbying	28	13
Improving medical care	27	9
Promoting, improving profession and standards	15	50
Researching and reporting on drugs and treatments	9	8
Preserving doctor-patient relationships	5	3
Opposing government medicine	4	15
Regulating schools and hospitals	1	5
Keeping doctors informed	1	24
Keeping fees down, lowering fees	4	--
Unifying, organizing doctors	--	2
Policing the profession, eliminating quacks	--	2
Protecting the public	--	1
Representing the doctors	--	1
Don't know	8	8

Over half of the people who know A.M.A. are able to specify things they like about it, while a fourth reveal things they dislike. The public again lists maintenance of professional standards, tests and reports on drugs and treatments, postgraduate education for doctors, health education, and public relations as laudable A.M.A. activities. Their list of likes compares closely with the purposes they ascribe to A.M.A.

The Association's opposition to government medicine heads the list of things the public dislikes about A.M.A. Every twenty-fifth person (4%) mentions he dislikes the A.M.A.'s stand on this issue. Political activity and lobbying and

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WHAT LAYMEN LIKE MOST about AMA



MENTIONED BY

its professional standards 12%
its tests, reports on drugs, etc. 11%
information to doctors, idea exchange 10%
public information, relations 8%

WHAT THEY LIKE LEAST—

its opposition to gov't. medicine 4%
its political activity 3%

protection of incompetent physicians are also listed by about one in every 50 persons (3%, 2%).

What things about the A.M.A. do you—

Like most?	People who know A.M.A.
Professional standards	12% (6% public)
Tests and reports on drugs, treatments	11
Informs doctors, exchange of ideas	10
Informs public, public relations	8
Polices profession, schools, hospitals	7
Serves, protects public	7
Serves, protects doctors	2
Improves public health	2
Fills need for doctors' organization	1
Other likes	7
Don't know	44
Don't know A.M.A.	--

Dislike most? (Don't like so well?)	People who know A.M.A.
Its opposition to government medicine	4% (2% public)
Political activity, lobbying	3
Protects incompetent doctors	1
Does not recruit enough doctors	1
Too powerful	1
Opposition to osteopaths, chiropractors, etc.	1
Undemocratic organization	1
Too self-centered	1
Not informing public, withholding information	1
Other dislikes	12
Don't know	75
Don't know A.M.A.	--

Doctors cite many services or activities of A.M.A. which they like. The most mentioned criticism of A.M.A. by doctors is that it does not poll members to get representative opinion. Thirty-three percent of the doctors say they like the *Journal* of the A.M.A. most and 25% mention its meetings and conventions. Twenty percent mention information and exchange of ideas and 10% mention its legislative interest and lobbying as its most liked services. Others say they like most its research and reports on drugs (9%), its public relations activities (6%), its promotion of high medical standards (5%), and its regulation of schools and hospitals (5%). Other phases of A.M.A. activities are mentioned less frequently.

Eleven percent of the 500 doctors surveyed say the A.M.A. is not representative and does not poll ideas. Another 9% do not like its political activity and lobbying, 6% criticize it for being remote and not interested in the individual physician, and 5% cite its conservatism. Five percent of the doctors object to its opposition to physicians' social security and to its public relations policies. Less than 3% mention they dislike the *Journal*, regimentation and interference, opposition to government medicine, and its dues. Yet 22% say there is nothing they dislike and 20% say they don't know what they dislike.

One half of those who know of A.M.A. and only a third of the doctors say it is run by majority rule, but other doctors do not necessarily object to this. A fourth (25%) of the people who know A.M.A. and half (49%) of the doctors think that a few doctors run it. About 17% of all the doctors indicate that, while they think it is run by a few, this situation is satisfactory to them. Of the doctors saying it is run by a few, 9% say this is true because the "interested ones run it"; 7% because "they don't poll doctor opinion"; 4% because "this is true of all organizations"; 4% because of "too much politics"; 3% because "it has to be run by a few"; and 7% because "it just is, that's all".

Doctors who say it is run by the majority most often mention the delegate system (10%) and the fact that all members are eligible to vote (5%).

Sixty-one percent of those who like A.M.A. say it is governed by majority rule, while 88%

of those who dislike A.M.A. contend it is run by a small number of powerful doctors.

Only minorities of the public and of doctors accuse A.M.A. of prejudice against any type of person or doctor. That prejudice exists within the Association is denied by 57% of those who know the A.M.A. and by 81% of the doctors. The only prejudice receiving significant mention is a prejudice against osteopaths and chiropractors, which is cited by 17% of the people who know A.M.A. and by 5% of the doctors.

More than half of the people who know A.M.A. rate its public relations success higher than doctors do. Fifty-six percent of those who know A.M.A. say the Association is doing a very good (27%) or a good enough (29%) job of getting along with the public. Yet only 42% of the doctors agree. A fifth of the public (20%) and almost half of the doctors are not entirely satisfied with its public relations success. The reasons most often given for saying A.M.A.'s relationship with the public is not as good as it might be are:

	Public	Doctors
Public needs more information	5%	* (less than ½%)
People are unaware of A.M.A.	3	4%
It's too self-centered	2	--
Too much ill-feeling	1	13
Always can do better	1	4
Too much unfavorable publicity	1	6
Hearsay, reputation	1	11

A.M.A. policies generally satisfy most doctors, according to the two-thirds of those who know A.M.A. and three-fourths of the doctors. Sixty-nine percent of those who know A.M.A. and 77% of the doctors say its policies are what doctors want. Only 6% of the people familiar with the Association and 10% of the doctors say that this is not true. Again, larger percentages of those people who dislike A.M.A. (31%) say its policies do not generally satisfy most doctors.

Doctors generally give an over-all endorsement to A.M.A. policies and give specific approval to several which are discussed later. Only two policies are mentioned by 1% or more of the doctors as examples of unpopular courses of A.M.A. action: 4% refer to the stand on social security coverage for physicians, and 1% mention the stand on doctor draft.

The public understands that the A.M.A., representing the profession, favors voluntary health insurance plans, but people are not so aware of association approval of group practice. Seven people in every ten recognize that voluntary health insurance is approved by the profession and only small fractions (6½%) think such insurance is still in disfavor. While only about a tenth of the public thinks that group practice is in professional disfavor, another four-tenths do not know what the official stand is.

A majority of the public agrees with doctors that local grievance committees are a good thing. Evidence of doctor and public approval of another A.M.A. policy is seen here. Sixty-two percent of the public and 81% of the doctors say, "Yes, there should be local doctors' committees to which dissatisfied patients can take their grievances". Twenty-two percent of the public and 13% of the doctors say "No". Doctors' chief reasons for favoring grievance committees include better understanding and public relations (31%), advantage of giving the patient a place to turn (20%), our works, our experience (8%), good for handling overcharges (8%), to control malpractice (6%), better than court or publicity (5%), local group is best (4%), and protection of the public (3%).

Doctors opposing grievance committees have four chief arguments: complaints should be handled by the individual doctor (3%), committees are not needed (2%), it only makes trouble (2%), and county or state society should handle (2%).

Highest professional opposition to local grievance committees is found among non-members of A.M.A. (24%) and small city doctors (22%) and general practitioners (20%).

Neither public nor doctors are critical of the Association's standards for medical schools. There is a fairly even balance between advocates of less stringent (Public, 4½%; Doctors, 6%) and more stringent (Public, 9%; Doctors, 3%) standards for medical schools. About 48% of the public thinks A.M.A. (or the medical profession) is strict enough in its standards for medical schools as against 88% of the doctors who think so. Doctors have much the same opinion (80%) of the A.M.A.'s standards for hospitals. This question about hospital standards was not asked of the public. Those who dislike A.M.A. have the highest proportions (22%)

who think the Association is too strict in its standards for medical schools and almost the highest proportion (16%) thinking that it is not strict enough.

Most people with opinions and a majority of doctors feel that the A.M.A. has about the right amount of control over individual doctors. Those who disagree tend to desire more, rather than less, control over doctors:

"Do you think the American Medical Association has too much, not enough or about the right amount of control over individual MDs?"

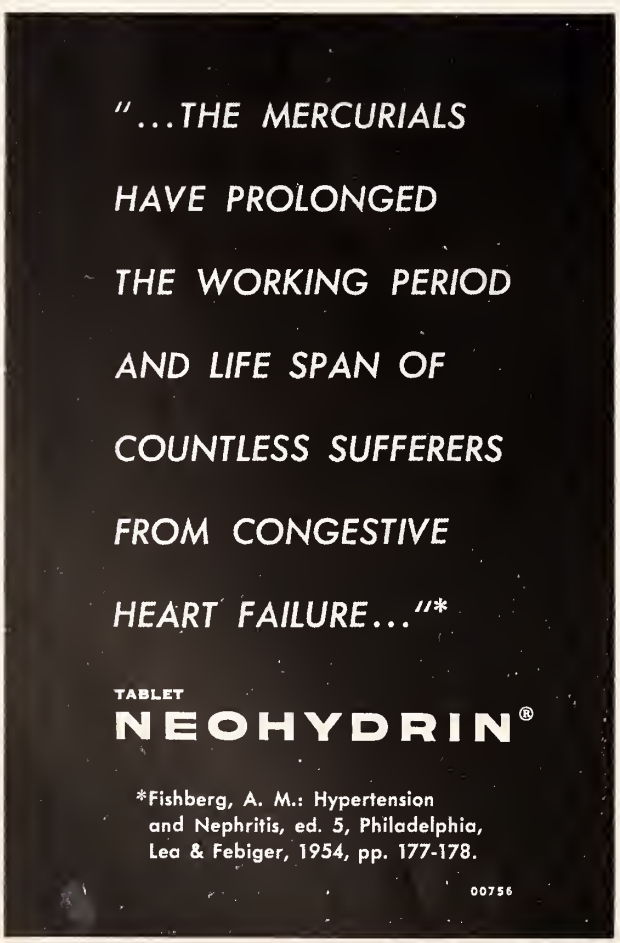
	People who know A.M.A.	Total public	Doctors
About the right control	39%	19%	66%
Not enough control	12	6	12
Too much control	9	4	6
No control at all	1	1	6
No opinion	39	18	10
Don't know A.M.A.	--	52	--

The 12% who say there is not enough control over the individual doctor most frequently say this is true because doctors do as they please (3%), A.M.A. doesn't control fees (2%), stop rackets or quacks (1%), and doesn't stop fee-splitting (1%). Again, those who dislike A.M.A. complain in over-proportionate numbers that A.M.A. has too much control over individual doctors (62% as compared to 9% of the public). Those who like the Association say that it has about the right amount of control (general public 9% and 39%).

The profession's care in accepting medical discoveries satisfies the largest proportions of both doctors and public, but doctors overwhelmingly are critical of advance reporting of experimental drugs in the news. Depending upon whether the public knew A.M.A. or not, individuals were asked: "Do you think that the A.M.A. (medical profession) is quick enough, too quick or too slow to accept medical discoveries?" Fifty-five percent of the public said A.M.A. was quick enough and 41% said the profession was quick enough. Eighty-three percent of the doctors agreed. Only 8% and 11% respectively of the public said physicians were too quick to accept new discoveries as against 3% of the doctors. Seven percent and 8% of the public said A.M.A. and the medical profession was too slow to accept discoveries and 4% of the doctors agreed. While doctors are critical of advance press reports of new drugs, believing that they do more harm than good (82%), the public more often approves (45%) than disapproves (35%) of such reporting.

Because the survey was conducted at the height of the Salk vaccine controversy a related question was asked to determine whether the polio vaccine reflected credit on the medical profession or not. Three-fifths of the doctors and three-fifths of the public said it has reflected credit. Sixteen percent of the public and 28% of the doctors said it has not.

Neither public nor doctors are very critical of the A.M.A.'s political activities, and five doctors in eight say they approved of the Whittaker-Baxter program. Although the A.M.A. has sometimes been criticized for its political activities, only one person in seven (15%) and one doctor is six (16%) say it is too active in politics. Those who dislike A.M.A. are especially opposed to its political activity (70%). Four percent of the public and 19% of the doctors say the profession is not active enough; 13% of the public





"AMA has about the RIGHT amount of CONTROL over individual MDs"



That is the prevailing opinion with laymen and doctors alike

LAYMEN	OPINION ON CONTROL:	DOCTORS
39%	about right	66%
12%	not enough	12%
9%	too much	6%

and 2% of the doctors say it is not at all active. One-fourth of the public (24%) say the profession and A.M.A. enters into politics in about the right degree; 53% of the doctors agree. Forty-seven percent of the public had no opinion on this question.

About every fifth doctor (22%) says he did not approve of the Whittaker-Baxter advertising campaign to fight socialized medicine, but his criticisms are usually of the methods used and not of the basic policy. Sixty-two percent of the doctors say they did approve of the program. Sixteen percent who said they did not approve said they opposed the method, 1% said they favored the Truman plan, and 2% gave both the above answers. Incidentally, 50% of all doctors say that Dwight Eisenhower's political philosophy comes closest to their own, 26% choose Robert Taft's and 17% prefer Franklin Roosevelt's.

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Portland Conference on Rural Health Attracts Record 40-State Attendance

THE ELEVENTH NATIONAL CONFERENCE on Rural Health March 8-10 was a graphic demonstration of the enthusiasm and down-to-earth interest which has been repeatedly shown by those who work to improve rural health.

Despite the fact that the meeting was held in the far Northwest, about 40 states were represented, and the 600-plus attendance ranked with the 1953 Roanoke, Va., conference as the largest so far. In addition, bad traveling conditions in the western states did not deter the many people in the area anxious to participate. Much of the large West Coast attendance could be attributed to the work of the Oregon State Council on Rural Health and the Oregon State and Multnomah County Medical Societies.

INDIANA'S REPRESENTATIVES

Dr. F. S. Crockett, Lafayette, Indiana, cofounder and chairman of the American Medical Association's Council on Rural Health, which sponsors the conference, said lay and rural attendance was the best on record. Physician attendance, he added, included many more practicing physicians than those in administrative positions.

Dr. Joseph E. Dudding, Hope, chairman of the Committee on Rural Health of the Indiana State Medical Association, and Mrs. Dudding attended the meeting.

The conference concentrated on the relationship of family and physician, a primary topic for these participants. Discussion included the family doctor's part in mental health and care of the aged, his responsibility to patients and the community, and their responsibility to him. Speakers also emphasized the role of the doctor as a hub for many rural activities and programs not directly related to health.

Opening the meeting, Dr. Crockett said the physician has become more "modern" and has many more facilities plus the knowledge to use them. . . . The doctor now has "so many positive benefits to give you that you are often well and back on the job before the sickbed has had time to get really warm."

MANY FARM GROUP SPEAKERS HEARD

Speakers and panelists during the three-day conference included Mrs. Albert Paulsen, Idaho Farm Bureau Federation, Wilder, Idaho; H. E. Slusher, Jefferson City, Missouri, American Farm Bureau Federation; Harold Berger and Norma June Belt, 4-H representatives from Hillsboro and Yamhill, Oregon; Dr. Herbert Mason, Beaverton, Oregon; Duane Bowler, manager of the Montana Public Health League; Jack Wright, director of the Bureau of Community Development, University of Washington, Seattle; Dr. J. Lester Henderson, Seattle, chairman of the mental health committee of the Washington State Medical Association; Mrs. Clarence Grund, Dallas, Oregon farm mother; Harold Stapleton, Dallas, Oregon, who represented the "father" on a panel; Laurence Ashley, a farm boy from Kelso, Washington; Patsy Kiser, 4-H, Kelso, Washington; the Rev. Robert N. Peters, Methodist minister at Sutherlin and Wilbur, Oregon; Dr. R. W. Farnsworth, general practitioner from Cedar City, Utah; Mrs. Clifford Zollinger, Portland, Oregon, a member of the Governor's Committee on the Aging, and Dr. Robert Heilman, director of chronic disease and hospital licensing, Oregon State Board of Health.

Voluntary health insurance and the need for special programs for rural persons, and other facets of the health insurance problem were discussed by Wendell Milliman, Seattle consulting actuary; Dr. Francis T. Hodges, San Francisco, president of the California Physicians' Service; Harley Libby, Jefferson, Oregon, president of the Oregon State Farmers Union; Helen Beck-

er, Lincoln, Nebraska, University of Nebraska agricultural extension service; Ben Robinson, Imbler, Oregon, past president of the Oregon Farm Bureau Federation; H. Tom Thorson, Okanogan, Washington, manager of the Okanogan County Medical Service Corporation; and Gordon Baine, San Francisco, vice-president of the American Associated Insurance Companies.

A highlight of the meeting was the annual banquet attended by more than 400 people, including five members of the Council and Mrs. Charles Sewell, 75-year-old Otterbein, Indiana farm woman who initiated the idea of the Rural Health Council and co-founded it with Dr. Crockett.

Dr. Crockett presided at the dinner and introduced the special guests, Mrs. Mason G. Lawson, Little Rock, Arkansas, president of the A.M.A. Woman's Auxiliary, and John Belt, Portland, president of the Student American Medical Association.

DR. MURRAY PLEADS FOR CIVIC ACTIVITY

Speaking at the dinner, A.M.A. President-elect Dwight Murray, Napa, California, physician, cited several successful rural health programs and said he wants physicians to take such community activities as "a personal responsibility."

"Much of the phenomenal medical progress of the past 25 years has been achieved because of the support—both moral and financial—obtained from the general public," he said. "The continued interest of the public in medical affairs will grow as the interest of physicians in matters outside the medical profession increases. That is why I am calling on doctors everywhere I go to mix with their neighbors and to share in their interests and their projects."

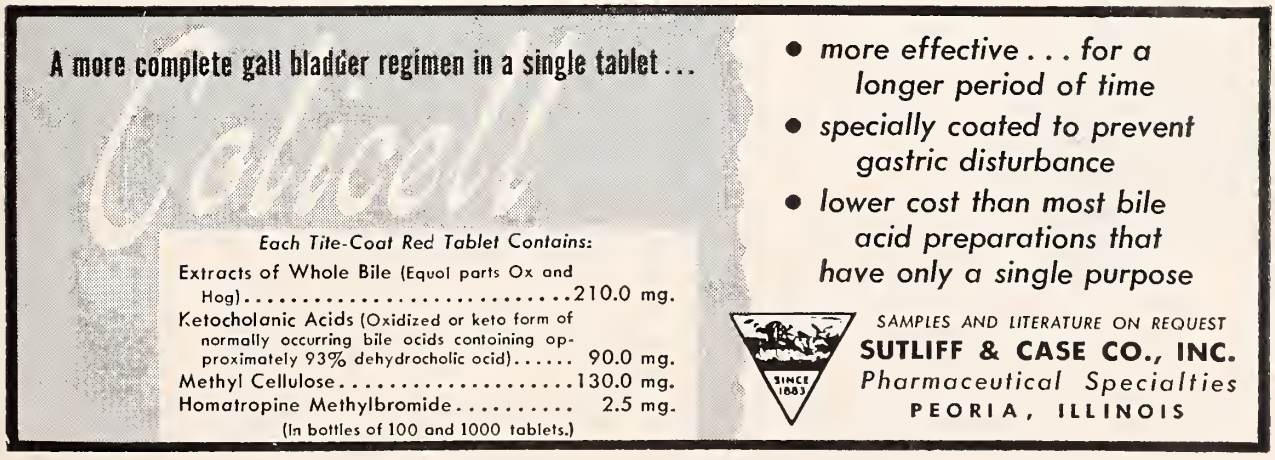
NATIVE ITALIAN WARNS OF "MAGIC WORDS"

Also speaking at the banquet was Louis A. Rozzoni, Clements, Calif., president of the California Farm Bureau Federation. Rozzoni, a native Italian, sketched his own story of successes and failures as a businessman and farmer and said it is not true that "only those who are successful speak well of this country."

Rozzoni said there are "always people who want something for nothing" and that we should stop trying to solve economic problems by "magic words such as 90 per cent parity," and by "old slogans I heard so long ago I thought I had forgotten them—like big versus small, privileged versus underprivileged.

"We are too prone now to listen to these seditious words, and to believe that our trouble is simply that someone else has more opportunities than we. We have a wonderful opportunity today, and even more so tomorrow, not by changing the system we have but by doing the same thing we are doing—only more of it and better."

He said those who try to solve the country's economic problems by taking from those who have and giving it to those who have not will solve no one's problems "except the socialists, who have been trying to do that for years."



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Medical Panorama—

A. W. Cavins, M. D.

Associate Editor

AQUILINE OR STRUTHIAN?

The *Bulletin of the Jackson County Medical Society* (K. C., Mo.) is frequently enlivened by a sparkling editorial from the radioactive pen of its editor, G. Wilse Robinson, Jr. A typical example is the one from which the following excerpts have been plucked, and all are ripe and juicy. He begins by speaking of the Governor of New York—but go on from there:

At a recent conference on education in his own state he proposed that the only solution to the crisis in the public schools "is through a system of federal grants," i.e., federal aid to education.

This statement might be seemly coming from a poor state which lacked funds within its border that could be tapped for this purpose, a state that paid little into the federal treasury. When the Governor of the great State of New York, however, asks for federal aid for his schools, that is pure demagoguery.

Federal aid and federal grants come from the people, not from some monster Santa Claus who makes his headquarters in Washington. People pay federal taxes, then these monies are used to pay federal expenses and federal grants. The Governor, when he asks for federal aid for his state for a purely local problem, is confessing that he hasn't guts enough to ask his own legislators to increase taxes enough to pay the state's own personal bills; rather, he wants the federal legislators to assume the onus, tax New Yorkers, send some back to their state for their schools, and send some of it to other states on a proportional basis. New York, being the richest state in the Union, must see some of its money go elsewhere, since if it gets federal aid, the other 47 states will also.

How much of an opportunist can one become?

* * * *

But don't stop here—read about our National Bird:

The American public is mesmerized these days with "federal grants." Hospitals, roads, farms, and many other projects receive federal grants . . . money which grows on trees in D. C. and is passed out to all concerned at no cost to anyone. It is money that comes into being by fiat, is really quite painless to acquire, and it is the greatest of all modern day delusions.

It is also a club. The bureaucrat in the home of the great white father acquiesces to the request of the states, providing they do the job his way. Then he is willing to give back to the states some of the money which its citizens have paid to his department in taxes.

Why do Americans fall for this completely cockeyed idea? Why do they sigh in relief when the federal government pays the bill, when really they are footing it themselves? Why can't they face reality and pay enough local, county, and state taxes to provide these vital services which must be met?

It has been said that the American Bald Eagle is our national bird . . . the symbol of all that is good and great in the United States of America. This is also a delusion and a snare. These days our national bird, according to our actions, is the ostrich. He alone of all known creatures thinks he can by-pass danger by ignoring it. He sticks his head in the sands of time and lets his future and ours go by without a thought.

An ostrich is an awfully stupid bird.

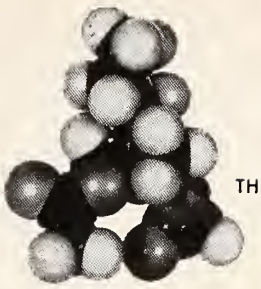
G. Wilse Robinson, Jr.

Are we not right about Dr. Robinson? Here is an example of a medical man who has ideas about the welfare of his country, and is not afraid to air them. No one can accuse him of being an ostrich—but what of the rest of us? Hm-mm?

TRAFFIC ACCIDENTS AND DOCTORS

In *The Wisconsin Medical Journal* for February 1956 there is an editorial which will find disfavor in some quarters, but which should be hailed by that part of our population which has its feet on the ground and hopes to live out its *full* allotted time on this globe and finally expire without benefit of gasoline. In case you're interested in the automobile hazard, the article is reprinted here. Incidentally, it is encouraging to learn that 400 doctors and others took enough interest in the matter to travel to the meeting in Detroit.

Nearly 400 physicians and industrial health experts recently met in Detroit to take a long and searching look at the most prevalent form of man's inhumanity to man—the automobile accident. If Dr. Elmer Hess, president of the American Medical Association, startled the teen-age set by proposing to ban night driving for anyone under 18 years of age and worried their elders with the suggestion of periodic driver physicals for



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General Surgery, Two Weeks, September 10
Thoracic Surgery, One Week, June 4
Esophageal Surgery, One Week, June 11
Breast & Thyroid Surgery, One Week, June 18
Gallbladder Surgery, Ten Hours, June 25
Fractures & Traumatic Surgery, Two Weeks, June 18
Varicose Veins, Ten Hours, June 18

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, June 18
Vaginal Approach to Pelvic Surgery, One Week, June 11

MEDICINE—Electrocardiography & Heart Disease, Two-Week Basic Course, July 9
Gastroscopy & Gastroenterology, Two Weeks, September 10

RADIOLOGY—Diagnostic X-Ray, Two Weeks, September 17
Clinical X-Ray, Two Weeks, by appointment

PEDIATRICS—Neurological Diseases: Cerebral Palsy, Two Weeks, June 18

UROLOGY—Two-Week Course, October 8
Cystoscopy, Ten Days, by appointment

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those over 50, he may also have shocked a good portion of the public to the realization that drastic acts such as these appear to offer one hope of ending the "blood bath" on our highways.

The American people, he said, have demonstrated that traffic statistics are making little impression on their sensibilities. Last Christmas, we killed 609 of our fellow citizens in motor car collisions. "A week later, we celebrated the advent of the New Year by disposing of nearly 400 others in like fashion."

"What sickening madness is this? Has the automobile become our Frankensteinian monster? Have we Americans added to the list of repugnant 'isms' a new and more detestable way of life—moronism? Are we to be governed by horsepower rather than horse sense?"

Without exception, safety experts point to the fact that the socially maladjusted individual is almost chronically involved in accidents, either as cause or victim. Such persons drive as they live—emotionally unstable and mentally confused.

Medicine's responsibility in the automotive age is abundantly clear. Because it, more than any other group, sees the cumulative horror of traffic accidents, it must be among the leaders in changing public attitudes toward driver licensing and suspension. It can learn to prescribe "no driving" for those with many types of physical and mental ailments. It must press for widespread understanding of simple first-aid procedures and the necessity for rapid transportation of the injured to places of adequate treatment. It must cooperate in the gathering of accurate data so that an epidemiologic approach to traffic accidents can be applied in dealing with the host (driver), the agent (automobile), and the environment (highway). The physician's knowledge of anthropology must be utilized to construct machines around the men who use them. Instruments and controls must be treated as extensions of the appendages and the nervous and sensory systems. When physicians treat victims, they have a duty to discover how the accident occurred.

Medicine truly has an important role in proving that injury and death need not be the inescapable price of motion. As Doctor Hess has very appropriately concluded: "We don't need luck; we need horse sense to go with our horsepower."

And the guts to apply the horse sense.



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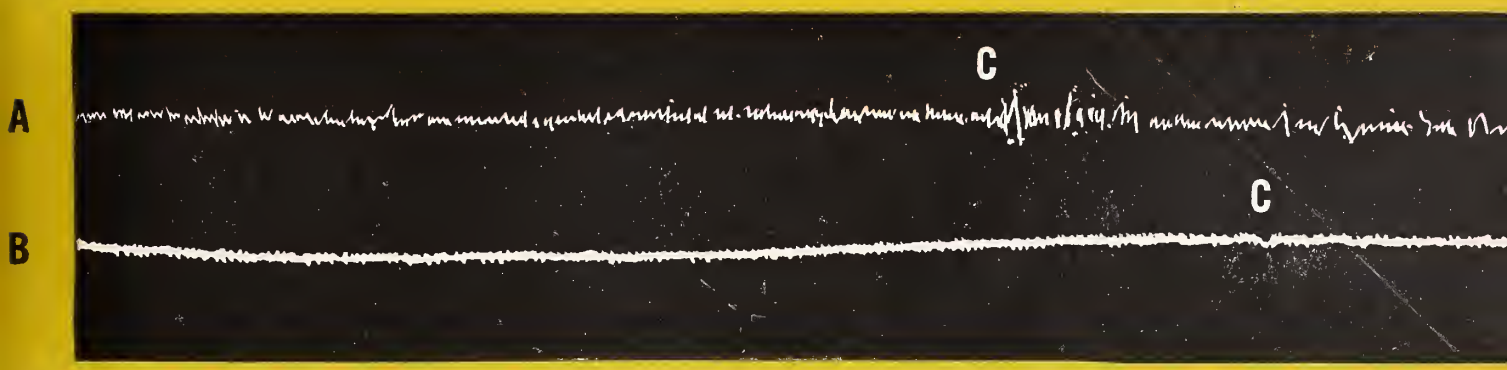
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1. Dickel, H.A., et al.: West. J. Surg., April, 1956.

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The Indiana Medical Education Foundation: Its History and Status

JAMES W. DENNY, M.D.

Indianapolis

IMPORTANT CHANGES came about as the result of the Flexner Report in 1910; changes that so drastically altered the nature of the teaching problem that medical school budgets can hardly be stretched to cover basic expenses. Costs increased primarily as a result of (a) the higher admission standards, (b) the insistence on competent, fully-trained, full-time faculties, (c) the emphasis on experimental science in the pre-clinical years, (d) the extension of clinical facilities in the later years, and (e) the general integration of medical education with the rest of the system of higher education.

In the period covered by the two World Wars, when the schools instituted these fundamental reforms, increasing endowments helped to absorb increasing costs. But at the same time the depression, and later the inflation, have taken their toll. In any society today the medical school is the cornerstone of the nation's health structure. If we permit our medical schools to economize by snipping away at their teaching schedules then in the long run we shall lose much more than any seeming immediate gains will afford us.

Virtually all medical teaching today stems from three basic sciences: biology, chemistry, and physics, each of which in turn has splintered into smaller and smaller specialities. We are coming more and more to accent the preventive features of medical practice, striking hard at the circumstances—physical, genetic, environmental, and psychological—that give rise to disease, thus striving to cut down illness at the earliest possible link in the chain of events.

The medical school curriculum today is jammed to the hilt with facts. To add more to the curriculum courts the possibility of adding another year and more expense for the M.D. degree. The road to medical practice is already too long and too expensive; both should be reduced if possible. We as doctors can do little to reduce the curriculum but all of us can do a lot to meet the rising expenses of a medical education by giving active support to the A.M.E.F. This is the instrument created so that we may have a central point to send our gifts and to distribute them.

Now! What do the medical schools do? Besides turning out 6,500 new doctors annually, the medical schools:

1. Teach 27,000 undergraduate medical students.
2. Provide refresher courses for 17,000 practicing physicians.
3. Train 11,000 graduate doctors, residents, interns, specialists and others requiring special knowledge.
4. Teach 8,000 non-medical students taking medical courses.
5. Instruct 16,000 dental, pharmacy, nursing and technical students.
6. Carry on and direct research projects costing approximately $32,000,000 annually.
7. Make available to 2,000,000 men, women, and children free hospital and clinic services valued at $100,000,000 annually, almost as much as the schools' budgets.
8. Function as nerve centers and fountainheads for the advancement of medical science and for the development of new techniques and knowledge.
9. Furnish leadership and counsel for thousands of professional and lay health organizations and agencies throughout the country.

To help Indiana University Medical School to do its part in all these things The Indiana Medical Education Foundation was established at my request in 1951. This foundation accepts

all funds coming from National A.M.E.F. Its board of directors consists of six representatives from the medical school and a like number from the Indiana State Medical Association. The dean of the medical school annually submits in writing a list of financial needs and after discussion these are approved or rejected. To date no money has been used for salaries except to help in securing new teachers and then for only one year. The following table is a résumé of the financial help we have given to I. U. School of Medicine.

Year	Number of Contributors (Indiana physicians and Auxiliary members)	Total Contribution	Amount Distributed to I.U. School of Medicine by Trustees of Indiana Medical Education Foundation
1951	18	$ 766.00	
1952	1217	58,152.54	
1953	829	33,991.66	$12,000.00
1954	1140	40,323.74	14,167.00
1955	750	25,148.91	48,876.00
1956			55,500.00
	3954	$158,382.85	$130,543.00

The maximum individual gift $1,000.00; minimum gift $1.00.

In addition we have at present approximately $100,000.00 in the trust fund for a future rainy day.

Some may not agree with the idea of a trust fund such as we have established. Let us consider the following advantages:

1. It determines positively where our money is to be used, thus keeping it out of the general university fund.

2. It has been an excellent public relations builder between the physicians and our medical school.

3. The trust fund can be drawn upon at any time to meet an unusual emergency in our I. U. Medical School.

4. The trust fund can accept bequests of any size or nature in addition to funds as they are now being raised.

The doctors of Indiana can be proud of our first few years of effort and should not be discouraged. While only about 35% of our members have contributed in the past it is to be hoped that all eventually will give annually to this worthy project. Our medical school is second to none and its influence keeps our level of medical practice on the same high plane. Let us be sure we continue to keep both above reproach.

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A Story That Warms the Heart

MANY PERSONS HAVE TESTIFIED and millions of words have been spoken at Congressional hearings in Washington on the social security amendments (H. R. 7225).

Lost in the maze of testimony, so often the case because people today want knowledge packed in easy capsules to be swallowed at a gulp, are the words of a man whose name few people have ever heard. He is Henry Viscardi, president of a manufacturing company known as Abilities, Incorporated, of New York.

Mr. Viscardi, like many other people, including A.M.A. officers, appeared before the Senate Finance Committee on March 1.

In his testimony, Mr. Viscardi stressed one point: he was definitely opposed to lowering the eligibility age to 50 for totally and permanently disabled people.

This statement, coming from Mr. Viscardi, is not only unusual but heartening because Mr. Viscardi was born without limbs.

"I have spent my life close to this problem of disability," he told the Senate committee, "and I have a great faith in solutions which can be obtained in a competitive, free enterprise spirit in our country."

And with that opening statement the story he had to tell, which was relayed to me by Paul R. M. Donelan of our Washington office, would warm the cold heart of even a Nero or a Dracula.

"I was born a crippled child, horribly deformed, with no lower limbs, and I spent the first seven years of my life, consecutive years, in one hospital," he said, adding:

"And when I was a child, I remember asking my mother, 'Why me?'

"And she told me that when it was time for another crippled boy to be born into the world, the Lord and His counselors held a meeting to decide where he should be sent, and the Lord said, 'I think that the Viscardis would be a good family for a crippled boy.' "

With that kind of background, Mr. Viscardi today heads a manufacturing company, founded three years ago on an $8,000 loan. In the first year of business, the little company grew to 59 employees—all of them disabled persons who could not get work elsewhere.

He said that the first production line in this plant received a competitive contract, the lace cable assemblies that are a component of the firing mechanism of sabre jets, in the early winter of 1952, and the first four employees were hired. Among the four men "we had but five usable arms."

During the first year the company paid back, with interest, the $8,000 borrowed from local citizens, and netted profits in excess of $52,000. During the second year the company grossed in excess of $400,000 in sales, and in the third year the company grew to 169 employees—all of them disabled—and its gross sales were in excess of $600,000.

These "totally and permanently" disabled persons made a striking contribution to the economy of their community and their country: they produced goods valued at $1,248,700; they received salaries of $668,500; they paid $22,650 in social security taxes, $6,200 in withholding taxes, $4,830 in disability payments to the state, and they returned $2,067,790 in new wealth to their community. During these three years it would have cost the community and the local government $415,850 to have supported these people on relief rolls.

He told the Senate committee:

"Their disability is because of prejudice and aversion and ignorance on the part of the in-

dustrial and commercial community, and what troubles me is that, should we stigmatize our disabled people and put on an age limit of 50, we might destroy the opportunity for them to be productive, and we might condone some of the ignorance and some of the prejudice that exist which prevent them from exercising their abilities and not their disabilities.

"If we could only, in communities of America and in commerce and industry, shake the ancient superstitions which make us divide our world into able and disabled persons, and the prevailing belief that the man who has lost his limbs is different from other people. From a medical point of view, sure, he is different; but in society and industry it is his abilities that count and not his disabilities. . . .

"There are no disabled veterans and there are no disabled people—only people.

"The extremes of physical suffering carry with it a great complement, which is the patience to continue to struggle for the right to be considered the same as the rest of the world, and not different.

"There is nothing that can be substituted for this basic human right; no honors, no pensions, no parades, no subsidy, can replace the wishes of every person who has known disability to live and work in dignity, in free and open competition with all the world, not as a different person, but, rather, as the same as others, with varying degrees of weakness and strength and complementary qualities to offset the extremes of physical make-up."

After telling the Senate committee that every one of his 169 employees "could qualify for permanent disability under terms of this law," Mr. Viscardi left the stand with this philosophy: "But I have the belief in other solutions to the problem if we can only try them."

—George F. Lull, M.D.,
Secretary-General Manager, A.M.A.



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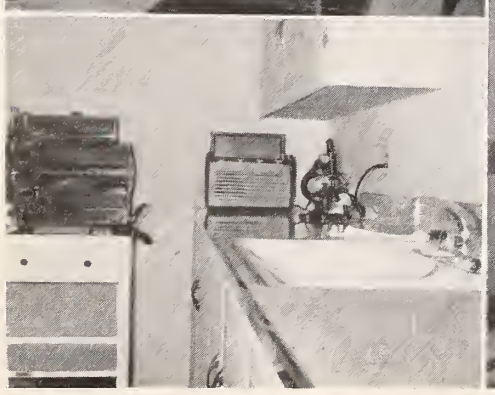
Progress—Pictorially

Indiana's small town physicians keep offices "in step" with medical achievement. Modern quarters facilitate faster treatment of patients resulting in better service to more patients.















When Dr. B. D. Wagoner built his new contemporary office in Union City several months ago, he chose location and plans with great care. The 30′ by 60′ split cement block and redwood one-story building is at the edge of town across the street from Union City hospital. Union City, in Randolph county, has a population of about 4,000. It is on the Indiana-Ohio state line. Union City, Ohio is its twin city. It is in the center of good farming land. The building has its own large parking lot.

Attractive permanent flower boxes stretch along most of the front of the structure and plants form an important part of the interior decor.

Entering the front door, patients step quietly across the vinyl asbestos tile flooring of the waiting room to the chest-high partitioned receptionist's desk to be greeted by Mrs. Charleen Davis, R.N., the office nurse.

Waiting is pleasant in the Wagoner office where lightweight modern, but comfortable, furniture faces the battery of windows across the front. A large picture window has a vertical and horizontal blind, adjustable to light at all times.

Your turn to see the doctor and you go down a hallway (one on each side of reception desk) and enter Dr. Wagoner's private office, one of the four consultation and examining rooms, one of the two minor surgery rooms, or a pediatric room. Each square foot of space is utilized to advantage—the small wall desk in lower picture is an example.

Other facts: the gas heat and air-conditioning plants are combined; random acoustical tile on all ceilings; walls soundproofed; indirect lighting; electric outlets 30 inches from floor; windows of thermopane; a bathroom at end of each hall; small laboratory.

Interior was **designed** by Mrs. Wagoner—can be converted to quarters for two doctors. She proved she was part of the team by painting the interior herself.

Down in southern Indiana at Salem, Washington county, Dr. E. R. Apple has a new Bedford limestone, concrete slab and redwood modern office building. Overall measurements are 72′ by 32′. Dr. Apple shares space with Dr. DeJean, a dentist, at left in top photograph.

A chipped marble roof deflects heat; rubber and vinyl tile floors are easily cleaned and quiet; walls soundproofed and consultation rooms paneled; sliding doors are used throughout.

Doctor and dentist enter door at top center; patients go directly into 22′ by 20′ shared waiting room.

The nurse makes appointments privately at wall phone desk in nurse's lobby. Patients are greeted by a receptionist shared by doctor and dentist. Her desk is centered and partially partitioned by a wall of corrugated tangerine plastic. When the patient arrives the nurse confers with her in the small lobby, secures her file and prepares her for consultation or examination.

Below, Dr. Apple receives records of patients prior to each consultation. A corner of one of the three 8′ by 10′ examining rooms is shown and at bottom right, the small drug room and laboratory.

The waiting room has an open rafter ceiling; luxurious draw draperies; modern furniture, some scaled for children; an aquarium of tropical fish; and continuous high fidelity music.

Dr. Apple's space includes 3 examining rooms, a physical therapy and X-ray room; the nurse's lobby; 1 consultation room; 1 drug and lab room and 3 closets. He shares the reception room, dark room, recovery room, 3 restrooms, utility room and an attic room.

All windows are fixed thermopane. There is a central oil heating and air-conditioning unit.

The new office is 4 blocks from the business district. Salem has 4,000 citizens; the county approximately 20,000. It is an agricultural community.



Last of the trio of new office buildings of physicians practicing in towns of less than 10,000 population is the redwood structure recently completed by Drs. James D. Kubley and James S. Robertson in Plymouth, Marshall county, in north central Indiana.

Top left picture shows entrance with driveway and walk divided by a tall masonry planter. Full length picture windows and under-the-eaves short windows create a light, cheerful aspect. Koroseal flooring is used which utilizes the radiant heating system best.

Radiant heat was used, the architect said, because "it is a sort of psychological, physiological heat—the building can be kept at lower, more healthful temperatures because warm floors give a sense of comfort and well-being."

At upper right patients in waiting room look directly into receptionist's booth, where receptionist and medical assistant have all records within easy access.

Interiors are redwood and Philippine mahogany. From the comfortable waiting room chairs patients have a wide-scale outside view. A glass and planter partition separates waiting room from the hall.

Building has an emergency room, small drug room, consultation rooms, two treatment rooms; room for diathermy, electrocardiograph, etc.; X-ray and dark room; a lavatory for patients and one for the staff; and a dressing room for each treatment room.

Left, bottom, is Dr. Robertson in his private office. Center, the autoclave in a small emergency room is being checked. At right, Dr. Kubley goes over mail in his office.

Other details include indirect lighting; the satisfactory use of ordinary kitchen cabinets throughout at sizable savings; off-street parking with entrance and exist at both ends of the lot.

Drs. Kubley and Robertson are Marshall county natives, I.U. graduates—and brothers-in-law.



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Deaths . . .

Herbert M. Senseny, M.D., 71, died March 12 in St. Joseph's Hospital, Fort Wayne, where he had been under treatment for a heart condition for several days. Dr. Senseny had been a practicing physician in Fort Wayne since 1912.

Born in Toledo, Ohio, he received his premedical training at Western Reserve University, Cleveland, in 1906. Four years later he received his medical degree from Johns Hopkins University School of Medicine at Baltimore. After internship at Milwaukee County Hospital, Dr. Senseny was in general practice in Iron River, Michigan, for a year. He practiced in Fort Wayne for one year before going to New York in 1913 for special training at the Manhattan Eye, Ear, and Throat Hospital. Returning to Fort Wayne he established his practice as a specialist in ophtholmology and otolaryngology.

Dr. Senseny served as a lieutenant with the Army Medical Corps in France during World War I where he was assigned to a hospital unit.

He was an active member of Fort Wayne Medical Society, the Indiana State and American Medical Associations, church, civic and fraternal organizations.

George B. Metcalf, M.D., 64, Anderson physician for 36 years, died in Robert W. Long Hospital, Indianapolis, March 13. He had entered the hospital for observation.

A native of Gerrard County, Kentucky, Dr. Metcalf had been a resident of Indiana most of his life. He was graduated in 1920 from Indiana University School of Medicine. He taught school for eight years before entering medical school.

Dr. Metcalf was a former secretary of Madison County Medical Society, and was a member of the Indiana State and American Medical Associations.

D. Jacob Schlesinger, M.D., Hammond physician and surgeon, died March 14 in St. Margaret's Hospital, Hammond, a few hours after suffering a heart attack in his home. He was 64 and had not been ill previously.

Dr. Schlesinger was a native of Chicago where he was graduated from the Chicago College of Medicine and Surgery in 1914. He served his internship in city and county hospitals at St. Paul, Minnesota, and then returned to Chicago for residencies in tuberculosis sanatoria. He served in the Army Medical Corps during World War I, assigned to special tuberculosis work. Dr. Schlesinger established his practice in Hammond in 1919.

He served as secretary of Lake County Medical Society in 1923. He was a member of county, district, Indiana State and American Medical Associations. Dr. Schlesinger also held membership in several civic and fraternal groups in Hammond.

Clayton L. Rice, M.D., 46, died suddenly at his home in New Haven March 17. He had been in practice in New Haven for a year and a half.

Dr. Rice was born in Richmond, received his degree in medicine from Indiana University School of Medicine in 1936, and served his internship and residency at City Hospital, Indianapolis.

During World War II, he served as a medical officer with the rank of lieutenant in the U. S. Navy for three years. He was in the European theater and participated in the invasion of Normandy.

Dr. Rice was a member of the Fort Wayne Medical Society and the Indiana State and American Medical Associations.

Omer H. Stewart, M.D., 74, Aurora physician for the last 35 years, died March 24 in Christ Hospital, Cincinnati, where he had been a surgical patient for two weeks.

Dr. Stewart attended the Hospital College of Medicine in Louisville where he received his degree in medicine in 1907. He practiced in Ireland in Dubois county for several years before going to Aurora. During World War I he served as a captain in the Army Medical Corps with overseas duty in Germany.

Dr. Stewart was a senior member of Dearborn-Ohio County Medical Society, the Indiana

State and American Medical Associations. He formerly served as a member of the Committees on Control of Cancer and Physical Therapy of the state association.

Claude S. Black, M.D., former president of the Indiana State Medical Association and a practicing physician in Warren for more than 50 years, died in Marion General Hospital March 28. He had been critically ill since March 23 when he was admitted to the hospital.

Dr. Black devoted his entire professional career to the care of residents of his native county. Born in Huntington county, he left there first to attend the Medical College of Indiana at Indianapolis where he received his degree in 1905. Again during World War I he left to serve as a lieutenant in the U. S. Army.

Dr. Black's long years of service to professional organizations began in 1921 when he was named secretary of the Huntington County Medical Society and at the same time a member of the Committee on Scientific Work of the state association. He was councilor of the 11th District Medical Society from 1922 to 1927 and again in 1944-45. In the intervening years he served as president of Huntington County Medical Society, was a member of several state committees, and delegate for several years to ISMA conventions. Dr. Black was named president-elect of Indiana State Medical Association in 1949 and assumed the presidency in 1950. From 1952 until his death he had served as a member of the Grievance Committee of ISMA. He was also a director of Blue Shield.

Dr. Black was a senior member of Huntington County Medical Society and a Fifty Year Club member of Indiana State Medical Association. He was also a member of American Medical Association.

J. Arthur Swails, M.D., 85, Acton, retired physician, died in his home March 28.

Dr. Swails was a native of Marion county and taught school for several years in Shelby and Marion counties before entering medical school. He received his medical degree in 1899 from Illinois Medical College in Chicago. Returning to Acton he practiced there for 48 years before retiring.



Claude S. Black, M.D.
1880-1956

Carl J. Langenbahn, M.D., South Bend urologist, died in St. Joseph Hospital March 29. He had been hospitalized for three days. Dr. Langenbahn was 55 years old.

He was a native of Pulaski county. After obtaining his medical degree from Northwestern University College of Medicine in 1928 he entered general practice in South Bend. In 1937 he received his master's degree in urology from the University of Pennsylvania School of Medicine and had specialized since.

During World War II Dr. Langenbahn served as a major with the 110th General Hospital in France for three years.

He held memberships in the St. Joseph County Medical Society, the Indiana State and American Medical Associations, Chicago Urological Society, Detroit Urological Society, and the American College of Surgeons.

John Randolph Gillum, M.D., 77, died March 30 at his home in Terre Haute. He had been a practicing physician for 50 years and for many years specialized in ophthalmology and otolaryngology.

Born in Rockville, he was the son and grandson of physicians. He obtained his degree in medicine from Jefferson Medical College in

Philadelphia in 1904. Following a year's internship in Philadelphia, Dr. Gillum established his practice in Terre Haute. During his career, he went to Europe on several occasions for postgraduate study.

Prior to World War I he was one of the founders of the Associated Physicians and Surgeons Clinic in Terre Haute. He served with the Army Medical Corps with the rank of captain during World War I.

Dr. Gillum had received his 50-year pins from both the Indiana State Medical Association and the Rockville Masonic lodge.

In addition to his professional affiliations, Dr. Gillum was also active in music circles. He was a former member of the Terre Haute Civic Orchestra and a past president of Wabash Valley Civic Music Association.

Dr. Gillum was a member of Vigo County Medical Society, the Indiana State and American Medical Associations, the American Academy of Ophthalmology and Otolaryngology, the Indiana Academy of Ophthalmology and Otolaryngology (past president) and the Wabash Valley Aesculapian Society.

Richard H. Fox, M.D., 87, veteran Knox county physician, died April 3 in Good Samaritan Hospital, Vincennes. He had been ill for six months.

For the last 21 years Doctor Fox had practiced in Bicknell and before that he had practiced in Freelandville for many years. He was a native of Knox county and received his medical education at Kentucky School of Medicine in Louisville where he was graduated in 1898.

In 1948 Doctor Fox became a Fifty Year Club member of Indiana State Medical Association. He was a senior member of Knox County Medical Society and the American Medical Association. He also held church membership and was affiliated with several lodge groups.

Among survivors is a son, Dr. Maurice S. Fox, Vincennes.

Robert C. Hamilton, M.D., retired industrial surgeon, died in St. Catherine's Hospital, East Chicago, April 3 following a short illness. He was 68.

Dr. Hamilton, who lived at Highland, was formerly surgeon for Inland Steel. He joined that firm in 1916 and served as company physician and surgeon for 38 years. He was vice-president and director of the Security Savings and Loan Association.

Dr. Hamilton was a native of Clarksdale, Missouri and received his first degree in dentistry from the Chicago College of Dentistry in 1911. He then entered the Chicago College of Medicine and Surgery (now Loyola University) where he received his medical degree in 1916.

He was a member of Lake County Medical Society, the Indiana State and American Medical Associations, and also held fraternal and lodge memberships.

Jacob S. Sagel, M.D., 55, died suddenly April 5 in a Miami, Florida hotel. He had been a Gary roentgenologist since 1934. Dr. Sagel had been in Florida three days and was expecting Mrs. Sagel to join him for a two-week vacation.

A native of Minneapolis, Dr. Sagel received all of his collegiate and medical training at the University of Minnesota, earning his doctor of medicine degree there in 1927. He returned to the university to instruct in radiology from 1931 to 1934 when he became roentgenologist at Methodist Hospital, Gary. He established his own laboratory and practice in 1938. Dr. Sagel was a veteran of World War I.

He was a member of Lake County Medical Society, the Indiana State and American Medical Associations, the American College of Radiology, professional, fraternal and church organizations.

Henry L. Hummons, M.D., 83, Indianapolis practicing physician for 53 years, died April 5.

Dr. Hummons was a native of Lexington, Kentucky, and a 1902 graduate of the Medical College of Indiana at Indianapolis. He established his practice the following year and for many years had maintained offices at 729½ North West Street. He was one of the founders of the Senate Avenue YMCA and of the Witherspoon United Presbyterian Church.

Dr. Hummons was a member of Indianapolis

Medical Society, the Indiana State and American Medical Associations, and the Aesculapias Medical Society. He was a Fifty Year Club member of ISMA.

His son, Dr. Francis D. Hummons, was associated in practice with him.

Charles J. Adams, M.D., 73, Kokomo physician, died April 7 after a seven-year illness. He retired in 1950. He was a specialist in ophthalmology and otolaryngology.

Dr. Adams was a native of Lafayette and received his medical degree from Indiana Medical College, School of Medicine, Purdue University, at Indianapolis in 1906. Dr. Adams was associated for many years with his father-in-law, the late Dr. J. L. Moulder, in Kokomo.

He was active in medical organizations, serving as Howard County Medical Society secretary and as vice-chairman and chairman of the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association. He was also a member of American Medical Association and the American Academy of Ophthalmology and Otolaryngology. He was a veteran of World War I.

Dr. Adams also held membership in several lodge and civic organizations. He was a charter member of Kokomo Rotary Club and had been a leader in that group's program to furnish medical aid for underprivileged children.

Carl B. Sputh, Sr., M.D., died April 8 in his Indianapolis home. He was 71.

Dr. Sputh was a native of Indianapolis and had been in continuous practice in that city since 1917. He specialized in ophthalmology and otolaryngology. He was graduated from the old Normal College of American Gymnastic Union in 1904, received his pre-medical training at Butler University, and his medical degree from Indiana University School of Medicine in 1912. From 1913 to 1916 Dr. Sputh was health and physical director at LaCrosse (Wisconsin) State Teachers College.

After many years as a faculty member at Indiana University, Dr. Sputh was awarded a Master of Science degree by the university in 1941. From 1934 to 1941 he served as president of Normal College of American Gymnastic Union (now a part of Indiana University).

Dr. Sputh was a member of the Indiana and American Academies of Ophthalmology and Otolaryngology, the Indianapolis Medical Society, the Indiana State and American Medical Associations, the International College of Surgeons and the American Congress of Physical Therapy.

He was a former national president of Phi Epsilon Kappa gymnastic fraternity and a national vice-president of Phi Chi medical fraternity. Dr. Sputh had been a member of Indianapolis Athenaeum for 50 years and served as president from 1920 to 1954.

He was associated in practice with his son, Dr. Carl B. Sputh, Jr.

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NEWS NOTES—from State and Nation

Virologist Added to Pitman-Moore Company Staff

Dr. Anton J. F. Schwarz, a native of Munich, Germany, has joined Pitman-Moore Company, Indianapolis, as a virologist. He will be associated with Dr. Charles J. York, director of the pharmaceutical firm's virus research laboratories.

Dr. Schwarz has spent the last year and a half as a research associate at the Children's Hospital Research Foundation, Department of Pediatrics, University of Cincinnati College of Medicine, where he has been assistant to Dr. Albert Sabin, a leader in virology and polio research.

Dr. Schwarz received his degree in medicine at the University of Munich in 1951, served in a Munich city hospital in 1951-1952 in all branches of internal medicine. In 1953 he completed a year's rotating internship at St. John's L.I.C. Hospital, Long Island, New York. He served as a resident in general practice at Dobbs Ferry Hospital, Dobbs Ferry, New York before accepting the Cincinnati research post.

Dr. Herman C. Sprecher, Chicago, now is associated with Dr. Ray H. Burnikel in the practice of proctology at 527 Sycamore street, Evansville. Drs. Burnikel and Sprecher were residents at the same time at Milwaukee County General Hospital.

Dr. Sprecher is a 1939 graduate of University of Illinois College of Medicine and served his internship at Swedish Covenant in Chicago. He took postgraduate work and received his master's degree in proctology at Marquette University School of Medicine.

Instruction in Premature Infant Care Offered Graduate Nurses

Graduate instruction in the care of premature infants will be given by the nursing staff of the Methodist Hospital, Indianapolis. The four-week course has been organized with the advice of the medical staff, and upon the encouragement of the Indiana State Board of Health and the Committee on Maternal and Child Health of the ISMA. It is hoped that hospitals throughout Indiana will take advantage of this opportunity to send graduate nurses for special instruction. The first program will start on Monday, June 4, and run through June 29. The course will be resumed in September and function each month thereafter. Complete information may be obtained by writing the Graduate Nurse Program in Premature Infant Care, Methodist Hospital, Indianapolis 7.

Terre Haute Doctor Heads School Board

Dr. Joseph G. S. Weber, Terre Haute, has been named president of the Terre Haute Board of School Trustees for one year. He will serve a total term of four years as a board member.

Referring to his election, Dr. Weber said, "I feel that my election . . . combats, in a small way, that criticism frequently directed toward physicians . . . that they are too busy and not willing to work on community affairs."

Two Special Events to Be Held at Muscatatuck School

The Second Clinical-Pathological Conference will be held in Muscatatuck State School, Friday, May 18.

Dr. Orville T. Bailey, Larue D. Carter Memorial Hospital, Indianapolis, will demonstrate several exceptional cases. He is I. U. professor of neuropathology.

Dinner is scheduled for 6:30 and the scientific meeting for 8 p.m. Dr. David H. H. Thomas of England, who is consultant in mental retardation and rehabilitation with the World Health Organization of the United Nations, is tentatively scheduled to appear on the program.

On May 23, the Indiana Pediatric Society will hold its annual meeting at Muscatatuck State School. The principal speaker will be Dr. Leo Kanner, professor of child psychiatry at Johns Hopkins Hospital, Baltimore.

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*Bonica, J.J.; and Backup, P.H.: Northwest Med., 54:22, Jan. 1955.

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I. U. Doctors Have Paper in Symposium on Fungus Diseases

In the recently published book "Therapy of Fungus Diseases", four members of the staff at Indiana University Medical Center are represented by a paper on "Histoplasmosis: Pathogenesis and Immunology in Relation to Therapy." Drs. Parker R. Beamer, Dale M. Schulz, Dwain N. Walcher and Frank Vellios, of the Departments of Pathology and Pediatrics at Indiana University School of Medicine, are the authors.

The book is the result of an international symposium held under the auspices of the Division of Dermatology, Department of Medicine, School of Medicine and Medical Extension, University of California, Los Angeles, in June 1955. A total of 208 scientists participated, representing 24 states and 8 foreign countries. Fifty-five papers have been compiled and edited by Drs. Thomas H. Sternberg and Victor D. Newcomer of the sponsoring university staff. The symposium was made possible by the financial assistance of the Squibb Institute for Medical Research.

Applications for certification, American Board of Obstetrics and Gynecology, for the 1957 Part I examinations are being accepted. Candidates are urged to make such application early. Deadline is October 1, 1956. Applications for re-examination and requests for resubmission of case abstracts are also due before October 1. Full details may be obtained from Dr. Robert L. Faulkner, Secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

The fifth annual **Symposium for General Practitioners** on Tuberculosis and other Chronic Pulmonary Disease will be held in Saranac Lake, New York, from July 9 to 13, 1956. It is approved for 26 hours of formal credit for members of American Academy of General Practice.

This five day course is designed particularly for general practitioners and presented over a period short enough so that they may readily attend. Many of the sessions are informal panel

discussions with ample opportunity for questions from the audience.

The registration fee for the Symposium is $40.00. Further information and copies of the program can be obtained by writing Dr. Edward N. Packard, General Chairman, Symposium for General Practitioners, P. O. Box 262, Saranac Lake, N. Y.

Hospital Progress Report Made in Indianapolis

Each of the four Indianapolis hospitals planning major expansion made progress reports at the annual meeting of the Indianapolis Hospital Development Association.

St. Francis Hospital, Beech Grove, reported construction had been started on its 104-bed wing. The new Community Hospital reported patients would be accepted at an early fall date. Methodist Hospital's planned large addition is in the blueprint stage; and Norways Foundation Hospital reported completion of ground purchases and that work on blueprints was going ahead.

Schering Award Competition for Students Provides Six Prizes

Medical students in the United States and Canada may enter the eleventh annual Schering Award competition at any time before July 1. Entry forms have been distributed to all medical schools.

The three subjects chosen for the 1956 competition are: The Clinical Use of Adrenocortical Steroids in Collagen Diseases; Metabolic Aspects of Aging: and New Applications of Antihistamines in Medicine and Surgery. Manuscripts are due before September 30.

Both a $500 first prize and a $250 second prize are offered for the best manuscripts on each of the three subjects. Each medical student participating will receive a professionally useful gift. Papers should be submitted to the Schering Award Committee, Bloomfield, New Jersey.

The executive board of the **American Public Health Association** has selected November 12 to 16 dates for the 84th annual meeting of the



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association and 40 related organizations. Sessions will be held in Convention Hall, Atlantic City, New Jersey.

General theme of the convention is a continuation of the 1955 subject, "Where Are We Going in Public Health?" All sections will furnish programs in their specialties.

Headquarters of the American Public Health Association are at 1790 Broadway, New York City.

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Hill-Burton Grants to Indiana Reported from Washington

One new project for Indiana, the addition of a 68-bed unit to Ball Memorial Hospital, Muncie, has been announced by the Department of Health, Education and Welfare. Approval was given during February for a Hill-Burton grant of $124,000 in federal money for the Muncie project. Total cost is estimated at $842,453.

Three projects are under construction at a total cost of $8,919,794, including the federal contribution under the Hill-Burton Act of $2,366,730. The projects will provide 336 new hospital beds.

Dr. Frank M. Steele, a graduate of Indiana University School of Medicine in 1948, has joined the staff of the Muncie Clinic in the department of internal medicine. Dr. Steele is a native of Mishawaka. He served his internship at Indiana University Medical Center and was a resident for a year at the Indianapolis VA Hospital before entering the U. S. Navy during the Korean conflict. From 1952 to 1954 he was a resident in internal medicine at Long Beach VA Hospital and completed his cardiology residency there in 1955. Dr. and Mrs. Steele and their two daughters are now living in Muncie.

Dr. Kenneth L. Craft, Indianapolis, spoke on "Medical Otolaryngology" at the recent meeting of the Southern Section of the American Laryngological, Rhinological and Otological Society at Houston, Texas.

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Dr. Robert J. Rohn Assumes Cancer Research Post at I.U.

Dr. Robert J. Rohn, who has headed the Division of Hematology Research at Indiana University School of Medicine, has been named to the staff vacancy created by the death of Dr. Edwin A. Lawrence. He is now serving as director of cancer teaching and research. Dr. Rohn will devote full time to his university work. He will continue his teaching and work in leukemia research and direct the cancer program.

Dr. Rohn is a native of Ohio, graduate of DePauw University, and received his medical degree from Ohio State University School of Medicine.

Dr. Eldred F. Hardtke, psychiatrist at the Indiana University Psychological Clinic in Bloomington, served as a consultant for the work session on "Helping Students With Mental and Emotional Problems" at the Tri-State College Health Conference held March 2 and 3 in Highland Park, Illinois. This was the first regional conference resulting from the Fourth National Conference on Health in Colleges held in New York City in 1954 for which Dr. Hardtke served on the Committee on Mental Hygiene. The Tri-State Conference included representatives from all colleges and universities in Indiana, Illinois and Wisconsin and was attended by almost 200 registrants, including representatives from the Chicago office of the A.M.A.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE EXECUTIVE COMMITTEE

March 14, 1956

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; W. U. Kennedy, M.D.; Elton R. Clarke, M.D.; O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Robert Hollowell, attorney; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

Membership Report

Number of members March 14, 1956	3,780*
Number of members March 14, 1955	3,707
Gain over last year	73
Number of members December 31, 1955	3,973

* Includes 88 in military service (gratis)
89—$10.00 members (residents and interns)
285—senior members
60—members, dues remitted by Council
1—honorary member

Number who have paid AMA dues:

March, 1956	3,212
March, 1955	2,949
Gain	263

Headquarters Office

Mr. Bush and Mr. Amick reported on their activities during the past month.

On motion of Drs. Sicks and Clarke the executive secretary was instructed to go to Washington, D. C., on May 1.

Legislative Matters

Letter from Representative Bolton of Ohio and a letter from the Alaska Territorial Medical Association dealing with a study commission for nursing and the Alaska mental health bill were read to the committee.

On motion of Drs. Clauser and Clarke the secretary was instructed to set up a breakfast on May 1 for the secretaries of the Indiana delegation in Congress.

On motion of Drs. Kennedy and Sicks the secretary was instructed to arrange a dinner for the

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Indiana delegation in Congress in Washington the evening of April 30.

Organization Matters

Requests for remission of dues of a member from Vigo county, St. Joseph county, Indianapolis Medical Society, were approved on motion of Drs. Kennedy and Clauser.

Request of Physicians Casualty Association was refused by consent.

A resolution was read from the Floyd County Medical Society which was referred to the Council without recommendation, upon motion of Drs. Clarke and Clauser.

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Letter from the Clark County Medical Society regarding its fee schedule was read but no action taken.

Letter from the Wells County Medical Society relative to the action of the House of Delegates concerning fee schedules was referred to the Council on motion of Drs. Clauser and Sicks.

The secretary reported the receipt of a schedule of minimum charges from the Steuben County Medical Society.

A letter from the Floyd County Medical Society making inquiry as to the policy of the Association relative to the request of the Indiana State Podiatrists Association and a copy of the letter being circulated by the Indiana State Podiatrists Association were read, and upon motion of Drs. Kennedy and Clarke were referred to the Council

The request of the Interstate Postgraduate Medical Association for use of the mailing list was approved on motion of Drs. Clarke and Clauser.

Letters dated March 5 and March 9 from Mutual Medical Insurance, Inc., were read and upon motion of Drs. Clauser and Kennedy the action of the Board of Directors of Mutual Medical Insurance, Inc., in March of 1955 in reelecting Dr. Wemple Dodds as a member of the Board was approved. The letter of March 9 notified the Association of the expiration of the term of Dr. W. H. Howard of Hammond, and on motion of Drs. Clarke and Clauser, Dr. Howard was renominated for reelec-

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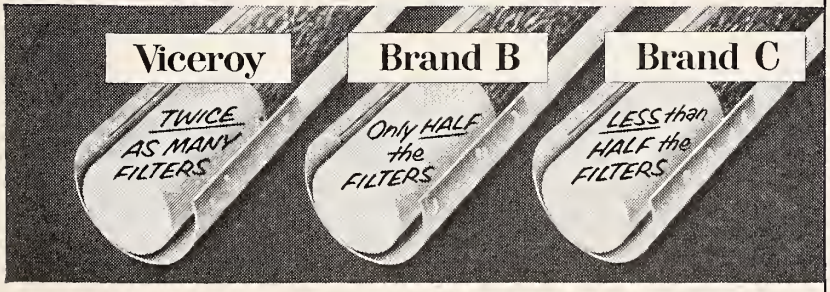


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tion to the Board for another three-year term at the March meeting of the Board in 1956.

Use of mailing list. On motion of Drs. Clarke and Clauser, the committee established the policy that use of the mailing list will be denied at all times when for personal uses.

Letter from Dr. Howard Marshall reporting on the meeting of the Committee on Maternal and Child Health was read and the actions were approved by consent.

Statements of Receipts and Expenditures for February for the Association and THE JOURNAL were approved.

The Journal

Report on advertising was approved by consent:

Total advertising scheduled for April, 1956	$3,215.68
Total advertising April, 1955	2,938.70
Increase	$ 276.93

Future Meetings

Invitation from the Ohio State Medical Association for the executive secretary to attend the Ohio state meeting April 10, 11 and 12, 1956, was approved by consent.

By consent it was agreed that Dr. J. William Wright and the executive secretary would represent the Association at the annual meeting of the Board of Directors of the Indiana State Chamber of Commerce in French Lick, April 13 and 14, 1956.

On motion of Drs. Clauser and Sicks the attorneys and the executive secretary are to be requested to attend the Legal Conference to be held in Chicago on April 19 and 20, 1956.

There being no further business the committee adjourned to meet again at 5:30 p.m., Saturday, April 28, 1956, in the Student Union Building, I. U. Medical Center, Indianapolis.

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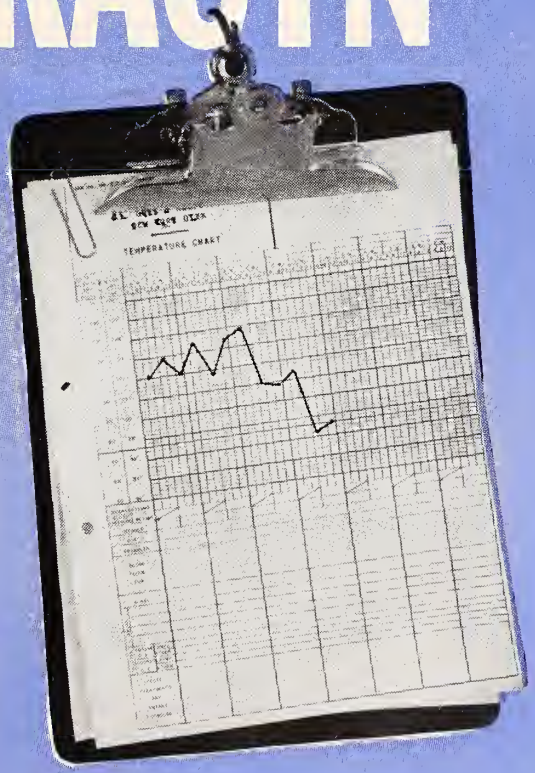
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News from the County Societies

Boone County Medical Society members met in Witham Memorial Hospital, Lebanon, April 3 at 7:30 for a routine business meeting and to view a film presented by a representative of Ortho Pharmaceutical Company on "Control of Conception". Thirteen members were present.

"Chemotherapy in Mental Illness" was discussed by Drs. Robert H. Maschmeyer and John W. Southworth at the March 19 meeting of **Cass County Medical Society** in the Ben Hur Motel, Logansport. Eighteen doctors and 11 guests attended the meeting.

During the business meeting, plans were made for an April 16 Civil Defense meeting with Wayne Schaefer, area Civil Defense director, as the guest speaker. Members of the dental society and the veterinarians were to join physicians for this meeting.

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Members of the Elkhart County Bar Association were guests of the **Elkhart County Medical Association** at a meeting March 8 in the Elkhart General Hospital. Following a 6:30 dinner, Edwin J. Holman, of the legal department of American Medical Association, Chicago, spoke on "Medico-Legal Matters".

There was a registration of 80 for the dinner and it was decided to make the combined meeting with the attorneys an annual affair.

Twelve members of **Greene County Medical Society** met at 8 p.m. March 14 in Freeman Greene County Hospital, Linton. During a routine business meeting there was a general discussion of the polio program and the accreditation of hospitals.

Dr. Robert J. Rohn, professor of internal medicine and coordinator of the cancer research program at Indiana University Medical Center, was the guest speaker at a meeting of the **Hamilton County Medical Society** which was held in Riverview Hospital, Noblesville, March 13.

Dr. Rohn spoke on "Lymphocytic Leukemia," illustrating his talk with 35mm. color slides.

Dr. Harold Shonk, president, reported unusually good attendance at the meeting and added that Dr. Rohn's presentation created renewed interest in cancer research and the local observance of National Cancer Week.

"Brain Surgery" was the title of a paper presented by Dr. J. Theodore Luros, Indianapolis, before the **Hancock County Medical Society** on March 26. The dinner meeting was held in the Hancock County Memorial Hospital in Greenfield. Several Auxiliary members were present for the dinner.

During the business meeting there was a lengthy discussion of the polio vaccine program and a general report of activities at the state level was made by Kenneth W. Bush, field secretary.

Howard County Medical Society members met at the Francis Hotel in Kokomo, April 3.

Dr. Charles F. Gillespie, Indianapolis, discussed ovarian conditions and surgery.

A personal invitation to attend the 11th District Medical Society at Flora on May 16 was extended by Dr. Charles L. Wise, Camden, district secretary.

Kenneth W. Bush, field secretary for ISMA, spoke of the effectiveness of AMA's stand on HR 7225. He also told of additions to the scientific recording library and services available to members.

Dr. Richard Hipskind, Fort Wayne, discussed "Cardiac Arrhythmias" at the March 6 meeting of **Huntington County Medical Society.** Fourteen members and two guest physicians attended the dinner meeting in the Moose Lodge.

During the business meeting members voiced opposition to the inclusion of doctors under social security; reappointed Dr. T. W. Omstead to the Blue Shield Advisory Council; and discussed at length the polio vaccine problem, making recommendations to state and national medical associations regarding the government's role in the program.

On April 3, the Huntington County society met again for dinner in the Moose Lodge with 15 members present.

Dr. A. N. Ferguson, Fort Wayne, was the guest speaker. His topic was "Angina Pectoris, Clinically".

Members of **Jay County Medical Society** entertained their wives at dinner in the Portland Country Club April 4.

Following dinner, members and guests heard Dr. Jefferson J. Klepfer, superintendent of Richmond State Hospital, speak on both administration details and aspects of treatment at the hospital.

Separate business meetings of the two groups were then held.

The society voted to increase dues to enable giving as a group to voluntary fund raising projects and appointed a special committee to apportion such gifts and recommend amount of future dues.

Members voted to refrain from giving third polio shots until everyone entitled to them had received the first two inoculations.

K. W. Bush, ISMA field secretary, spoke briefly on legislative and policy matters, and told of the availability of films for showing to various types of audiences, and of the tape recordings in the library at ISMA headquarters.

A joint dinner meeting of the **Jefferson-Switzerland County Medical Society** and the dental societies of those counties was held April 2 in the Elks Club in Madison with 25 attending.

Action was taken on several matters of importance. Provision for a dental staff at King's Daughters' Hospital, Madison, was made; no changes were made in hospital rules and regulations; motion was made to table adoption of a fee schedule; a dinner workshop meeting for physicians' assistants with Blue Shield as host was approved; and an advisory health committee to work with the welfare board was voted, selection of members to be made by the society.

Twenty members attended the business meeting of **Johnson County Medical Society** on

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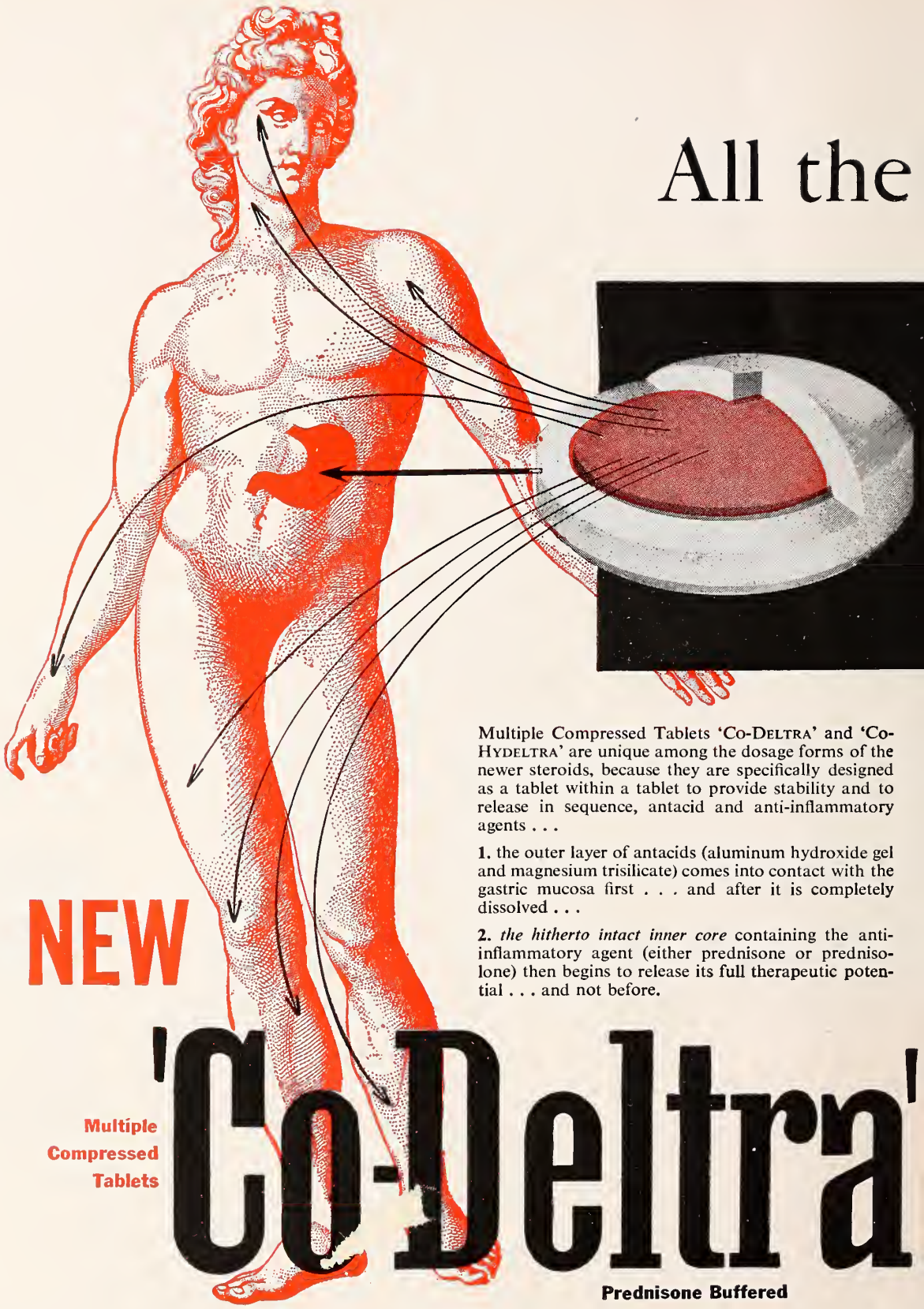
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1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* 158: 459, June 11, 1955.

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March 14 in the Johnson County Hospital, Franklin.

Plans were completed for a Health Day program to be presented March 27; approval was given for a Blue Shield dinner for medical assistants; and Robert J. Amick, field secretary, reported on bills in Congress and the Salk vaccine program.

Dr. Mila Pierce, professor of pediatrics at the University of Chicago, spoke on "Erythroblastosis" at a meeting of **Lake County Medical Society** on March 14 in Phil Smidt's restaurant at Whiting. Eighty-five members attended.

A public education program on pre-school immunizations was launched at the meeting. Adoption of the program resulted from a meeting March 4 of the 20-man council of the medical society. 50,000 leaflets directed to parents have been provided by the society. They stress the need to immunize pre-school age children against whooping cough, diphtheria, tetanus, smallpox and poliomyelitis.

The program has been undertaken as a result of a diphtheria epidemic in the Michigan City area and because of the decreasing percentage of children who are properly immunized against these diseases.

At a luncheon meeting of **Lawrence County Medical Society** in Dunn Memorial Hospital, Bedford, on April 4 members approved a Blue Shield-sponsored dinner for doctors' assistants; discussed an article on student loan funds; heard a report by Robert J. Amick, field secretary for ISMA, on Science Fairs, and fee schedules; and also heard a paper on "Public Health" presented by Dr. Howard Mitchell of the Indiana State Board of Health. Twenty-two persons attended the meeting.

"Leiomyoma of the Colon: a Case Report" was the subject discussed by Dr. James Kubley and Dr. James Rimel, at a meeting of **Marshall County Medical Society** April 4 in the Warana Restaurant, Plymouth.

At a business meeting following the luncheon members voted to endorse Dr. Otis Bowen of Bremen for state representative on the Republican primary ballot, and discussed the opportunity for a physician to establish a general practice in Argos.

Thirteen members were present and set the date of the next meeting for May 1 at noon in the Warana restaurant.

It was also reported that a nurse scholarship program has been organized to aid deserving girls who wish to enter nursing school. The Marshall County Advancement, Inc. will permit aid to three girls annually. Officers of the new organization are Dr. James Robertson, presi-

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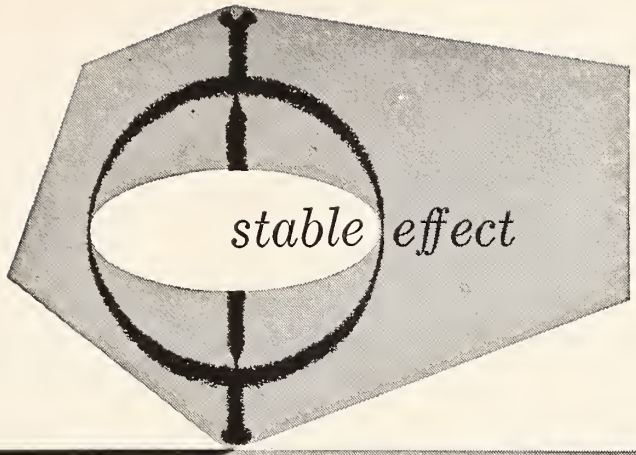
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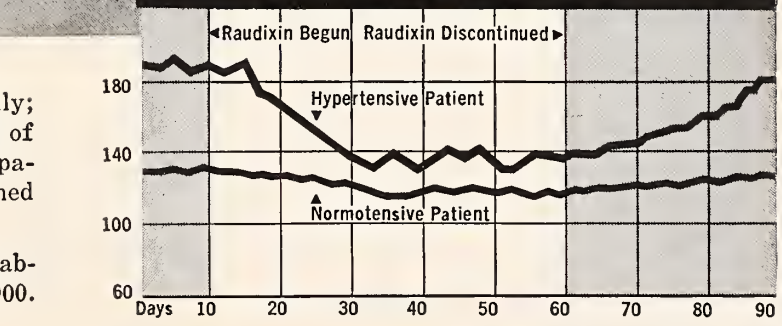
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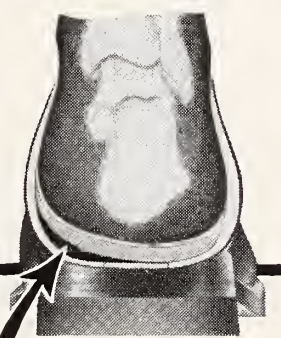
Miami County Medical Society's March 30 meeting was held in Veach's Steak House, Peru, with six members present.

At a business meeting many matters of policy were discussed, including the polio immunization program, fee schedules, and dues. It was announced that two doctors from Bunker Hill Air Base will meet with the society at their next meeting to discuss medical problems of the Air Force.

Kenneth W. Bush, field secretary, discussed films available through the state office; the Rural Health Committee meeting and Health Day programs; American Medical Education Foundation Week and the film "Danger at the Source"; and several routine matters.

Dr. H. E. Rendel was reappointed on the Blue Shield advisory board of the district.

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Dr. A. D. Dennison, Jr., Indianapolis cardiologist, was the guest speaker for the **Montgomery County Medical Society** meeting on March 15 in Culver Union Hospital, Crawfordsville. He discussed "Traumatic Heart Disease" and illustrated his talk with a number of slides.

Twenty-seven members were present for the evening meeting.

Thirty-two members of **Owen-Monroe County Medical Society** held a dinner meeting in the Graham-Van Orman Hotel in Bloomington on March 29.

A report on Science Fairs was given by S. D. Geiking of Indiana University, who expressed gratitude for the assistance the medical profession is giving to the program to encourage young scientists.

Dr. L. M. Mason, Terre Haute, spoke on "Fungus Infections of the Scalp" at the March 21 meeting of the **Parke-Vermillion County Medical Society.** Fifteen members attended the dinner meeting in Vermillion County Hospital, Clinton.

Eight members of the **Perry County Medical Society** met April 3 in the Perry county nurse's office in Cannelton for a business meeting.

All communications to the society were read and discussed; there was a general discussion concerning the advisability of giving injections to chidren in a doctor's office; and a report was made by Robert J. Amick, ISMA field secretary, of the action of Congress on bills of interest, fee schedules, and participation in the Science Fairs programs.

February 9 and March 16 meetings of the **Pulaski County Medical Society** were held in the Main Cafe in Winamac. Both meetings were business sessions with five members attending on each occasion.

At the first meeting election of officers was held and committees for the year appointed.

In March the society discussed the establishment of a cancer clinic with Mrs. Helen Ahrens, president of the Pulaski County Cancer Society.

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Putnam County Medical Society held a meeting March 9 in the DePauw University Union building in Greencastle.

Following dinner, the 14 members present heard Dr. William W. Krieble, Terre Haute, speak on "Heart Disease".

In a brief business meeting the society voted to return free polio vaccine to the state, preferring to use commercial vaccine except for the indigent.

The **Rush County Medical Society** and the Rush County Bar Association held a joint dinner meeting March 8 in the Durbin Hotel, Rushville, with 18 members present.

Special guests were Dan Cravens, Franklin, candidate for the nomination for governor, and Vance Waggoner, Rushville, candidate for the House of Representatives.

Robert J. Amick, field secretary, made a brief report on scheduled meetings.

Dr. Ott B. McAtee, Madison State Hospital, spoke on admissions procedure, treatment and discharge of patients.

Shelby County Medical Society's March 7 and April 4 meetings were both held in the W. S. Major Hospital in Shelbyville where dinner was served to 16 members each time.

At the March meeting the ISMA field secretary, R. J. Amick, made a general report on activities; a report was made on the addition to the hospital; it was voted to delay action on adoption of fee schedules; plans were made for a committee of the society to meet with their Congressman.

In April, Representative Ralph Harvey was present and answered questions of the members. He remarked that he favored lowering the retirement age for women under social security to 62; explained the reason for setting the age at 50 in disability cases as proposed in another social security amendment. He predicted that if H.R. 7225 does not pass, the Reed-Keogh bill will not get out of the House committee.

Dr. James H. Gosman, Indianapolis, presented the scientific program. He gave a paper on "Common Dermatological Problems".

Five members of **Spencer County Medical Society** met at noon March 27 in the Cotton Restaurant, Rockport, for a luncheon meeting. They heard a report by the ISMA field secretary on the status of several bills in Congress; fee schedules, and services of ISMA which are available to all members of the association. A general discussion concerning uniform fees for office and house calls followed.

Starke County Medical Society members met in Starke Memorial Hospital at Knox March 6 for dinner, a hospital staff and a society meeting. Seven members were present.

At the medical society meeting it was voted to write to senators and representatives regarding the society's opposition to H.R. 7225; K. W. Bush, ISMA field secretary, spoke on legislation, on the function of the Medical Defense Committee, and of services to members; and there was general discussion of fee schedules, the candidacy of one of the members for county coroner, and several community health matters.

It was also pointed out that Starke county doctors have a tape recorder in the doctors' waiting room at the hospital, keep a supply of tapes from the ISMA library on hand, and that doctors use waiting periods at the hospital to good advantage hearing recordings of recent scientific talks.

Members of **Sullivan County Medical Society** heard a report by Drs. Potts and Sunderland of Gibson City, Illinois, on their hospital, the steps they are taking to become accredited, their staff regulations, and the keeping of records, at a meeting April 5 in the Sullivan Hotel. Eighteen members and guests were present for the dinner meeting.

At a short business meeting following dinner, members heard a report by R. J. Amick, field secretary.

The fifth annual Medical-Civic dinner in the Hotel McCurdy, Evansville, sponsored by the **Vanderburgh County Medical Society,** attracted a capacity crowd of 300 physicians and guests on March 8 when Dr. Elmer Hess, president of the American Medical Association, was the speaker.

Propositions for a new addition to the Wabash County Hospital were discussed by Wilbur E. Ford, chairman pro tem of a Citizens Fact-

Finding and Advisory Committee, at a March 14 meeting of the **Wabash County Medical Society.** The meeting was held in the private dining room of the Wabash Cafeteria. Thirteen members were present.

Several doctors expressed their views on the new hospital addition and suggestion was made that money might be raised by public subscription.

Dr. Harvey C. Knowles, professor of medicine at the University of Cincinnati, spoke before members of **Wayne-Union County Medical Society** at Reid Memorial Hospital in Richmond on March 13. His subject was "Concepts of Treatment of Diabetes, Including Pregnancy and Juvenile."

A business meeting was held following dinner. R. J. Amick, field secretary, made a routine report of scheduled meetings, the current status of legislation, and ISMA policy on several health programs. A Blue Cross-Blue Shield representative discussed various types of coverage with the society members.

Fifty-two members attended the meeting.

The **Wells County Medical Society** met February 20 in the Community Building in Bluffton with 15 members attending.

The entire business session was devoted to discussion of plans and policies of the society.

An April meeting to be held with the Woman's Auxiliary was scheduled, and tentative plans for the annual Clinical Conference on October 3 were discussed.

K. W. Bush, field secretary, spoke on legislation from the association's viewpoint, the availability of tapes on the Rural Health program and the recent Heart Symposium at Indianapolis, and explained the Medical Defense Fund and its purpose.

Eight members of **White County Medical Society,** who will serve as the active hospital staff of the new White County Memorial Hospital, Monticello, met in the hospital March 28 to formulate plans for the opening of the new structure. The opening was scheduled for early April. President of the staff is Dr. Nolan A. Hibner; vice-president, Dr. Warren V. Morris, and secretary-treasurer, Dr. W. Martin Dickerson, all of Monticello.

"Pension Plans for the Professionally Self-Employed" was the title of a paper presented March 27 to members of **Indianapolis Medical Society** by Dr. Frank G. Dickinson, director of the Bureau of Medical Economic Research for the American Medical Association. The meeting was held in White Cross Guild Auditorium at Methodist Hospital. Dr. Ralph V. Everly, president, introduced Dr. Dickinson and presided at the business meeting.

Guests invited to hear Dr. Dickinson included members of the Bar Association, Dental Society, Medical Assistants' Association and the Woman's Auxiliary.

Five applications for membership were received by the Indianapolis society and five physicians were elected to membership. The new members are Drs. Edward F. Steinmetz, Robert J. Healey, Paul M. Waitt, Harry R. Boyd, and Karl Lee Manders.

A memorial tribute to Dr. Edwin A. Lawrence was read by Dr. Joseph C. Finneran. It had been prepared by a committee consisting of Drs. John A. Campbell, chairman, Finneran, and Harris B. Shumacker.

On April 10 the Indianapolis Medical Society met again in Methodist hospital for a routine business session and to hear Dr. J. Arthur Myers, University of Minnesota, the guest speaker. Dr. James H. Stygall, local TB control officer, introduced Dr. Myers.

During the business meeting a final report by the special committee on fee schedules was adopted, including a resolution to be presented to ISMA at the House of Delegates meeting in October.

Plans to organize the staff society of the new Community Hospital were formulated and a meeting for organization scheduled for April 24.

Six physicians made application for membership and the following physicians were elected to membership in the society: Drs. Reed P. Rice, Lawrence D. Benken, James Gordon Kidd, Jr., Albert Lea Blake, Robert J. Madden, and Donald F. Moore. The latter transferred from Jefferson county, Kentucky.

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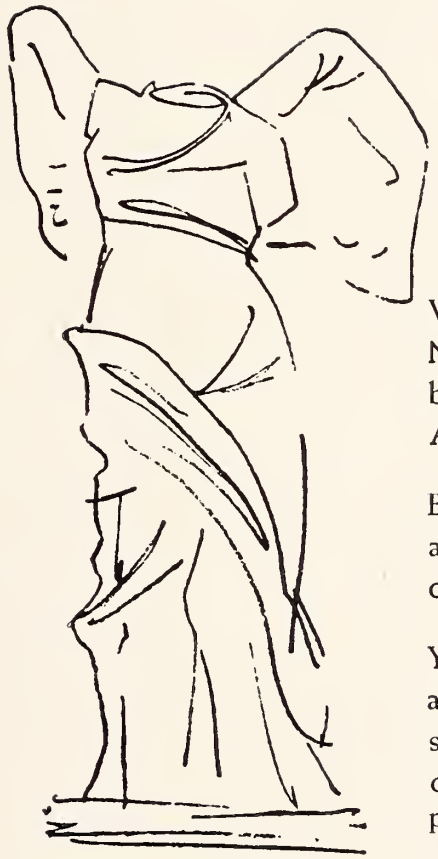
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2.	Sam I. Rotman, M.D., Jasonville	J. S. Brown, M.D., Carlisle	
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4.	Winship C. Callaghan, M.D., Greensburg	Robert A. Porter, Westport	Greensburg, 1957
5.	C. M. Schauwecker, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Greencastle, June 6, 1956
6.	Frank H. Green, M.D., Rushville	J. Frank Lewis, M.D., Liberty	Brookville, 1957
7.	Joseph F. Ferrara, M.D., Franklin	Arthur W. Records, M.D., Franklin	
8.	F. W. McDowell, M.D., Muncie	Clyde G. Botkin, M.D., Muncie	Muncie, 1957
9.	J. A. Van Kirk, M.D., Frankfort	Frank A. Beardsley, M.D., Frankfort	Fowler, May 23, 1957
10.	H. M. Baitinger, M.D., Gary	S. J. Brady, M.D., Gary	
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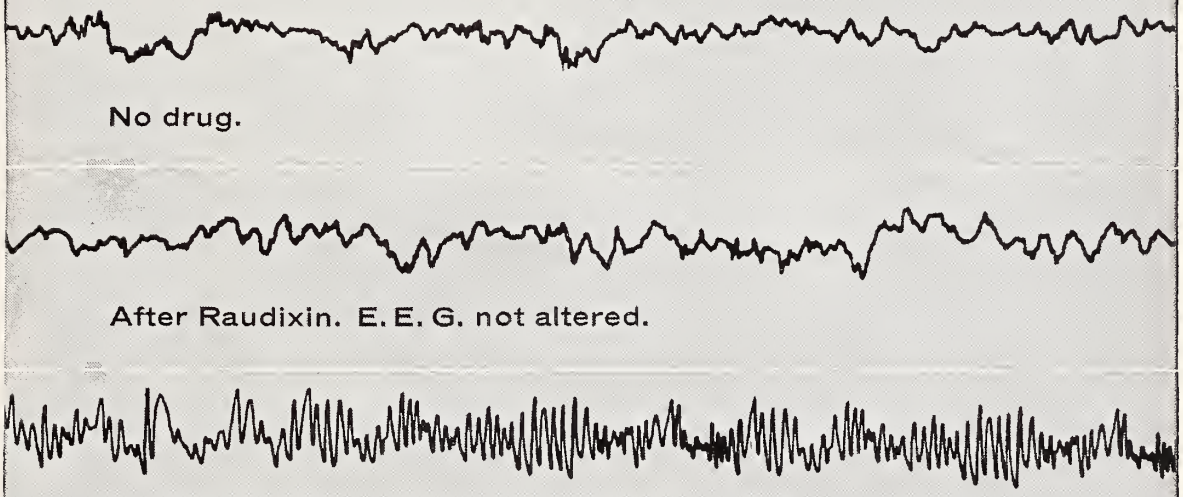
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Warrick	Arthur R. Rogers, Newburgh	R. P. Dimmett, Boonville
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Medical Panorama—

A. W. Cavins, M. D.

Associate Editor

FIRST, DO NO HARM

This is an ancient precept, yet still of primary importance in medicine. No matter how many centuries roll by, it will still be prime. The recent disturbances Down South have caused some to wonder at the many explanations and remedies offered, yet from out of the deep South comes an editorial in *the Journal of the Florida Medical Association* presenting an analysis of the physician's character which is truly fundamental and devoid of casuistry. Since excerpts would not do it justice, it is reprinted here in full, with our thanks to its author:

Primum non nocere is a dictum that should be engraved on every physician's writing hand the day he enters the practice of medicine. It is a maxim that should always be foremost in the physician's thought before he reaches for his prescription pad. Unfortunately, the scores of miracle drugs and panaceas that the prolific pharmacal companies bring forth each year give proof to the evanescence of most of their products and convincing evidence that a capsule has not as yet replaced a physician's task of proper thought.

Any physician would be hard pressed to name 50 drugs which he would really consider essential—yet an attempt to count the preparations listed in the Physicians' Desk Reference would be a formidable task. Why then the schism? Why then does the average physician, trained in a good medical school which gives him a firm and thorough education in therapeutics, suddenly become a voluminous writer of prescriptions containing medicines of unproved value, yet whose side effects may be worse than the presenting symptom complex he is treating? Why then does he write a prescription calling for a preparation most likely to have a shotgun effect even when he is certain that only one of the medicaments in the preparation is essential for a cure? It would indeed be a revelation to any physician to make a carbon copy of each and every prescription he writes in one day and at the end of that day to read them over and reassess the ones he honestly believed were going to benefit the patient solely by the therapeutic effect of the drug or drugs given.

One may rationalize that the public still identifies the physician with the herb healer of old and therefore expects a prescription for each complaint. It is true that many patients are unhappy unless they get a shot of B_{12} or $B_{56.5}$, or at least a pretty pink pill. So the physician accommodatingly acquiesces to the patient's demand, but, by so doing, he loses his role as a physician and becomes a drug dispenser.

The busy physician—often too busy to take refresher courses in medicine and unable to wade through the maze of articles in a jungle of medical journals—is bombarded daily by advertisements of drug firms and detail men always offering something newer, something with an added drug in it, or just something. To this bombardment is added the pestering of his patient who has just read of a new drug in his favorite magazine. Again, the physician betrays his role and once again becomes a dispenser by using these preparations before they have been properly evaluated.

Perhaps if one considers the field of antibiotics, the answer to the problem is almost found. Volumes have been written on the promiscuous use of antibiotics telling of their dangerous and disabling side effects, of the increasing bacterial resistance to them and of their possible sensitizing effects. On the other hand, the number of reactions and sensitizations is probably infinitely less than the number of persons in whom there would develop pneumonia, rheumatic fever, nephritis and other disease which may be the aftermath of a seemingly innocuous respiratory tract infection had not these drugs been used. It is likewise true that those who most strongly condemn the use of an antibiotic in any disease for which it is not specific, oft-time use it for "prophylactic measures." In other words all physicians use antibiotics when not specifically indi-

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Esophageal Surgery, One Week, September 24
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MEDICINE—Electrocardiography & Heart Disease, Two-Week Basic Course, July 9
Internal Medicine, Two Weeks, September 24
Gastroscopy & Gastroenterology, Two Weeks, September 10
Gastroenterology, Two Weeks, October 22
Dermatology, Two Weeks, October 15

RADIOLOGY—Diagnostic X-Ray, Two Weeks, September 17
Clinical Uses of Radioisotopes, Two Weeks, October 8

UROLOGY—Two-Week Course, October 8
Cystoscopy, Ten Days, by appointment

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cated because of their fear that if they do not use them, a worse disease or complication may develop.

It becomes evident then that the physician in many cases in which he offers a medication is not treating the patient as much as he is treating his own anxieties. There is the anxiety lest he disappoint a patient by not giving him a prescription; the anxiety lest he not be one of the first to use a new panacea, the anxiety that his diagnosis is not too accurate and that a shotgun preparation or antibiotic is better than a period of close observation. He further substitutes prescriptions because of the anxiety caused by his failure to realize that the limitations of present day medical knowledge are no fault of his own.

Recently, several excellent articles have appeared on the use of placebos. No one can doubt their value in selected cases. But let not the physician delude himself into believing that the average prescription he writes merely acts as a placebo. Let the physician realize that many of his prescriptions are not drugs for the patient, but are in reality a placebo for his own anxiety. In most cases, he is prescribing a potent drug, one which may change the clinical picture so as to delay an accurate diagnosis, one which may have side effects worse than the disease itself. All these dangers, however, are infinitesimal compared to the danger of the physician prostituting his knowledge and profession in order to allay his own anxieties. Therapeutics? Certainly. They are the basis of good medicine. But therapeutics for whom?

Physician, cure thyself!

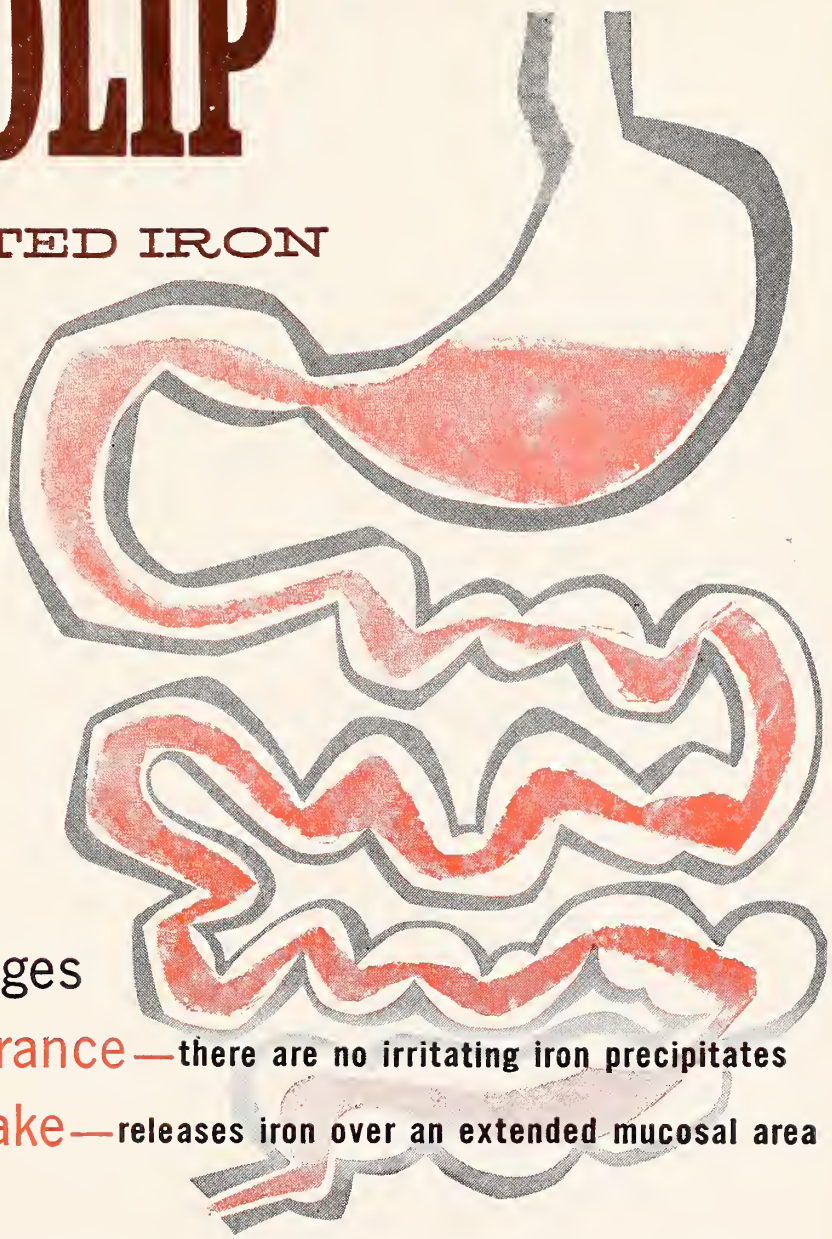


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The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

PASSPORT TO HEALTH

A simple idea may have fabulous possibilities for improving health and saving lives. It is that each individual should keep a lifetime log of his personal health, for the use of his physician at times when care is required. The idea was advanced by Dr. Carl A. Dragstedt of Northwestern University Medical School, writing in the Journal of the American Medical Association.

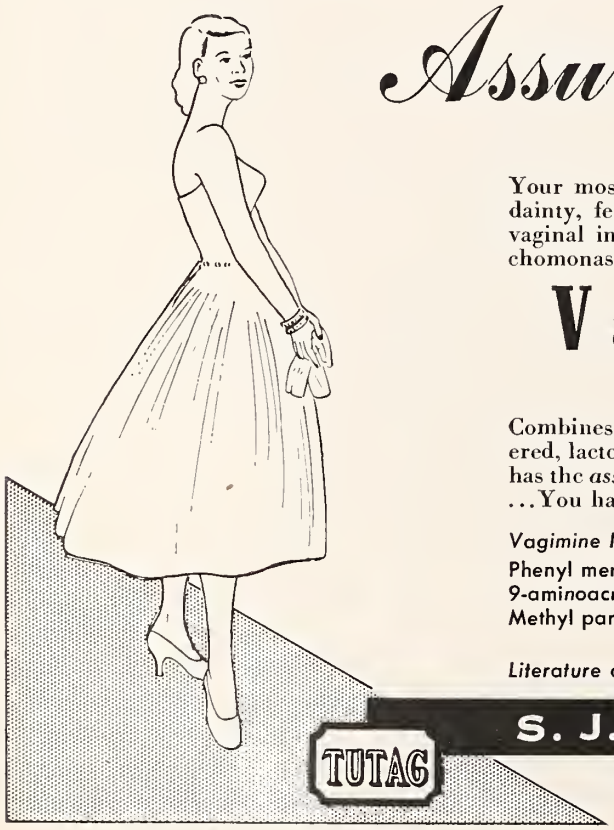
Information on past illnesses and treatment is clearly of value to the doctor when he begins to diagnose a patient's ills or check his condition. It is information the individual can expect to be asked for whenever he goes to a doctor, or to a hospital. It also has a bearing on his employability, and on such matters as insurance purchase.

It is really remarkable that so important a matter is by almost universal habit left to memory. Virtually the only formal records of medical history are those kept by doctors, hospitals and insurance companies. Yet the greatest usefulness of such a record is to the individual himself.

In the first place it would save time. It would help to reduce the sometimes incongruous formalities of admission for treatment. Most importantly, it would reduce the perils of error of memory, and would provide for those emergency situations when the patient is unable, because of injury or acute illness, to provide the information needed for most effective treatment.

The practical possibilities of this suggestion ought to be thoroughly explored by medical or other interested groups. If there is anything in the idea, the private organizations in the medical field should show their interest promptly. This is the sort of idea which will sorely tempt someone to propose a law.

—*Indianapolis Star*



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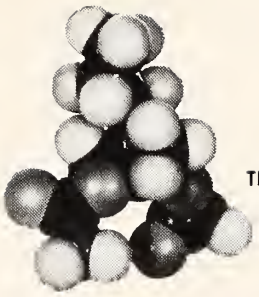
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Wanted: PHYSICIANS LOCATIONS

Three additional communities contacted the Physicians Placement Service of Indiana State Medical Association during April for assistance in securing doctors to locate in those communities. Several requests were also made by physicians who sought information on good locations to establish medical practice in Indiana.

The Placement Service, under the guidance of the Committee on Rural Health, furnishes each physician with a complete list of all Indiana communities needing doctors and also sends the list of interested doctors to communities which are seeking a physician.

Communities needing physicians are:

ARGOS—Marshall County—population 1,500. One elderly physician with a limited practice in community. Office building especially built for a physician available. A prosperous community. Contact Mr. Frank Snyder, President, Chamber of Commerce, Argos.

PENDLETON—Madison County—population 1,700 with a surrounding population of 3,000. Located near Anderson, Indiana where good hospital facilities are available. One physician in town. Dr. M. W. Dickey is leaving for a residency and wishes to have someone take over his practice. Office and home available at reasonable rent. Equipment available on easy terms. Contact Dr. M. W. Dickey, 103 E. State Street, Pendleton.

FRANKFORT—Clinton County — population 15,115. Opening for EENT and general practice. Located 40 miles northwest of Indianapolis and 22 miles southeast of Lafayette. Office and residence available. Dr. William W. Jones, 9½ W. Clinton St., Frankfort, wants someone to take over his practice; records, files and equipment available. Contact Doctor Jones or Mr. Everett Lucas, c/o Farmers Bank, Frankfort.

SEEK LOCATIONS

Physicians who asked about opportunities in Indiana were:

W. Wilson Wren, M.D. (general practice) Norristown State Hospital, Norriston, Pa.

David B. Haggard, M.D. (general practice) 687 Magnolia Dr., Fort Walton Beach, Fla.

James J. Sullivan, M.D. (available 1/57 general practice) U.S.S. Ajax, c/o Fleet Post office, San Francisco, Calif.

Lawrence F. Misanik, M.D. (general practice) 2912 Washington St., Apt. B, Camden 5, N. J.

Gene R. Hay, M.D. (general practice) 6912 Madison Avenue, Hammond, Ind.

Ambrose M. Price, M.D. (general practice) St. Margaret Hospital, Hammond, Ind.

Charles K. Liddell, M.D. (general surgery) U. S. Army Hospital, Fort Knox, Ky.

John W. Bengtson, M.D. (internal medicine) Veterans Hospital, Rocky Hill, Conn.

Richard A. Saavedra, M.D. (internal medicine) USPHS Hospital, Chicago 13, Ill.



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*Trademark 1. Report of Study by Army, Navy, Air Force Motion Sickness Team: J.A.M.A. 160:755 (March 3) 1956.

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D. C.—As might be expected, a presidential commission's report on veterans' pensions that also goes into the subject of non-service connected medical benefits is stirring up another controversy.

The President's Commission on Veterans Pensions, headed by Gen. Omar Bradley, World War II leader and postwar Veterans Administrator, conducted a study covering more than a year in time and a wide range of subjects. It produced a 415-page report and a total of 70 recommendations.

The seven-man commission's report has this basic premise: military service in time of war or peace should be treated as discharging an obligation of citizenship and not of itself as a basis for future government benefits.

The commission made this additional point: ". . . under conditions of modern technology and warfare, the national defense might be served equally well by a civilian in a scientific laboratory or a war plant as by a uniformed serviceman—and in view of total war and atomic weapons, perhaps with greater personal hazard to the civilian. This further suggests that the special needs that veterans have because of military service should not be confused with the needs that all citizens have in common for such things as education, health services and economic security."

With this in mind, the commission proposes the gradual elimination of non-service connected benefits and observes: "Their justification is weak and their basic philosophy is backward looking rather than constructive." Such benefits, it adds, should be limited to a minimum level and retained only as a reserve line for veterans who fail to qualify for basic protection under Old Age and Survivors Insurance (Social Security).

The commission then goes one step further by recommending an end to the present automatic "presumption of service-connection" procedure. Now, presumption of service connection is automatic and mandatory for certain diseases if the condition is diagnosed within a specific period of time following discharge. Instead, the commission would substitute medical determination for chronic and tropical diseases, psychoses, tuberculosis and multiple sclerosis, with each case decided on its own merits.

Other recommendations: (1) increased reliance on the OASI system for certain veterans benefits, (2) prompt counseling of all veterans

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placed on compensation rolls as to VA and federal-state rehabilitation programs, and (3) requirement of reasonable medical or surgical treatment before payment of compensation.

Representatives of veterans groups called before the House Veterans Affairs Committee to comment on the Bradley study complained that some of its proposals would be "extremely destructive" to certain aspects of veterans compensation.

NOTES:

Two committees of Congress, after long studies of **problems of narcotics, barbiturate and amphetamine addiction,** have come up with recommendations that the U. S. tighten penalties on narcotics peddling and smuggling, outlaw heroin and set up a central unit in the Federal Bureau of Narcotics to keep track of known addicts. The proposals were made by the Senate Judiciary committee and a House Ways and Means subcommittee.

The House committee also suggested a law for more stringent controls over barbiturates and amphetamines.

The Senate committee rejected the proposal backed by the New York Academy of Medicine for "clinics" where known addicts could go for regular doses of narcotics.

* * *

U. S. Public Health Service is advising private physicians as well as health officers to increase their use of **Salk poliomyelitis vaccine.** Although supplies now lag behind demand, the expectation is that before the summer is out the situation will be reversed. In line with this recommendation, PHS is urging that physicians use what supplies they have on hand immediately, depending on future production to take care of second and third shots.

* * *

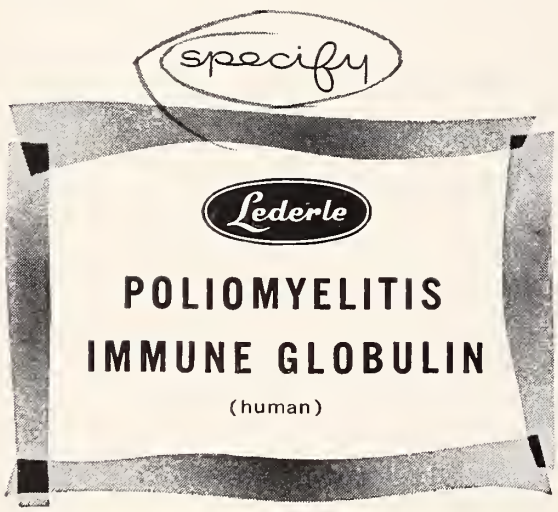
Because the President signed the military career incentive bill promptly, **physicians in uniform** received their pay raises starting May 1. The minimum boost (after two years' service) is $50 per month, the maximum (after 10 years) $150.

* * *

Private-profit nursing homes, hospitals and some other medical facilities soon will have an opportunity to obtain U. S. loans from the Small Business Administration. The limit is $250,000 per project, the interest rate usually 6 per cent.

* * *

If there was any question about it, the **AFL-CIO as a joint organization favors national compulsory health insurance,** as each group did before the merger. The AFL-CIO stand was taken officially for the unions by Nelson Cruikshank in testimony before the House Ways and Means Committee on a bill for increased payments for the medical care of public relief recipients.



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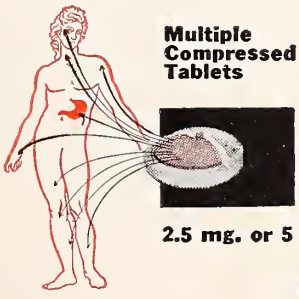
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References: 1. Boland, E. W., *J.A.M.A.* **160**:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* **158**:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* **158**:459, June 11, 1955.

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Books: Received and Reviewed

BOOKS REVIEWED

SPORTS INJURIES: PREVENTION AND ACTIVE TREATMENT. Christopher Woodard, Honorary Consultant to British Olympic Teams 1948 and 1952. Max Parrish and Co. LTD., London, England.

Doctor Christopher Woodard, who was honorary consultant to the British Olympic Teams in 1948 and 1952 discusses a wide range of sports injuries in this little book, and although some may differ with him on some of his methods of management of some of these injuries there is no doubt that the author speaks from long experience and with authority which gives considerable weight to even his more radical departures from conventional forms of therapy. Not only is the book of great interest to physicians, but it contains much of value to the lay reader, particularly coaches and teachers of physical education, as well as the athletes themselves. The author attempts to differentiate those injuries which should be managed by physicians and those in which reasonable precautions by the layman are adequate protection against ill effects. The author, who was a well known English athlete, now specializes in the treatment of soft tissue injuries in athletes and discusses his methods at some length in this book. He does not, however, limit his discussion to injuries, but devotes sections to such subjects as routine exercises, diet, mental hygiene and the use of drugs. The book is well illustrated and a considerable section is devoted to posed photographs to illustrate various exercise routines developed by the author, both for athletes and for those who want suitabe exercises for general hygiene.

LALL G. MONTGOMERY, M.D., Muncie.

DEMONSTRATIONS OF PHYSICAL SIGNS IN CLINICAL SURGERY by Hamilton Bailey. The Williams and Wilkins Company, Baltimore, 1954.

This book should be in the library of every physician. The book is based on the premise "The wards are the greatest of all research laboratories." The author stresses that diagnoses depend on facts obtained from a complete history and a thorough examination. Most of this small volume is devoted to the mechanics of the examination. This is supplemented by black and white and color photographs as well as a few line drawings. Each chapter is complete and each sentence is loaded with "meat." Each system is covered as it pertains to surgery. The book will serve as an excellent refresher in physical diagnosis although cardiology is lacking. The presentation is simple and clear. Many lessons can be learned and easily retained. This book has had 12 editions and several reprintings. It has been translated into four languages. The author is to be commended for such a simple, factual book containing a wealth of clinical information.

GEORGE N. LEWIS, M.D., Gary.

REPRODUCTIVE SYSTEM. THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS. Volume 2. A compilation of Paintings on the Normal and Pathologic Anatomy of the Reproductive System prepared by Frank H. Netter, M.D. 286 pages. Ciba Pharmaceutical Products, Inc., Summit, New Jersey.

This magnificent book is the second volume of illustrations by the well known physician-medical artist, Frank H. Netter. Those who have seen his work in the Ciba Clinical Symposia will realize what a wealth of visual education will be found in this monograph, while any who have seen the first volume of collected illustrations, THE NERVOUS SYSTEM will know almost exacty what to expect. The NERVOUS SYSTEM edition has already been exhausted and its popularity will almost certainly prompt an early reissue. That this present volume likewise will be enthusiastically received goes without saying. Not only is it a beautiful, spacious book with the characteristic lucid and accurate drawings by this distinguished artist, but the subject matter is the kind that will be particularly useful for the busy general practitioner or the practitioners of obstetrics and gynecology. The material is so arranged that it is ideal for a quick review of gross anatomy and related pathology, both gross and microscopic, for surgeon and non-surgical practitioner alike. The accompanying textual material also is in the nature of a review of a wide field of many aspects of the reproductive systems of both males and females, from youth to old age.

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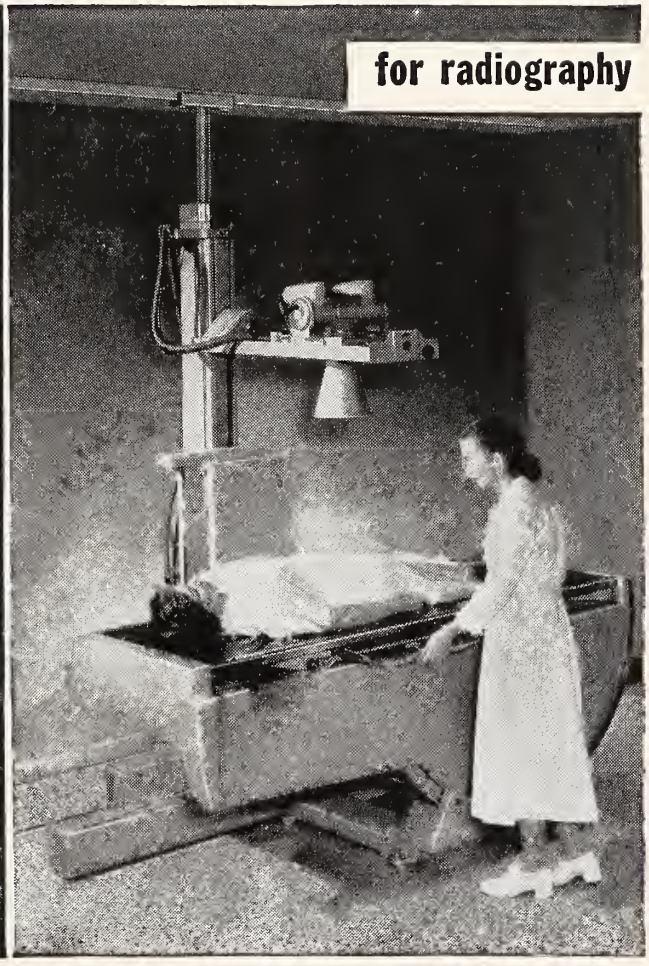
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Medical Education Fund Boosted by $10,000,000 Grant by Ford Foundation

A $10,000,000 program of grants to the National Fund for Medical Education has been announced by H. Rowan Gaither, Jr., president of The Ford Foundation.

The appropriation is intended to assist the National Fund for Medical Education in its efforts to strengthen the financial support for medical schools throughout the United States, both public and private, and to develop new sources of such support.

Grants from the $10,000,000 appropriation will be paid to the National Fund on a matching scale in a program that could last up to 10 years but might be accelerated to completion in five years, depending upon the rate at which the National Fund develops additional support for medical education. The maximum grant in any one year would be $2,000,000.

TO MATCH OTHER RECEIPTS

The sliding formula by which The Ford Foundation will match the National Fund's receipts is designed to give particular encouragement in the early years of the plan to increasing the contributions of existing donors and to attracting new donors.

In 1955 the National Fund raised approximately $2,147,000 in unearmarked funds for distribution to the nation's medical schools. If the Fund's receipts are of equal magnitude in 1956, the Fund would receive under the Ford Foundation's formula grants totaling 70 per cent of this amount, or $1,503,486. All contributions to the National Fund in excess of the 1955 total would be matched dollar for dollar, subject to the annual maximum of $2,000,000.

In succeeding years the Fund's receipts would be matched on a diminishing scale, but all receipts over the preceding year's total would be matched dollar for dollar, up to the $2,000,000 annual total.

The National Fund for Medical Education was incorporated in 1949 to campaign for funds, principally among corporations, to support medical education. Its funds, given for current operating expenses, are distributed to each of the 81 accredited medical colleges of the United States. S. Sloan Colt, chairman of the Bankers Trust Company, New York, is president of the National Fund for Medical Education.

The new appropriation is totally distinct from the $90,000,000 (endowment) appropriation announced by the Ford Foundation's board of trustees in December, 1955 to help privately-supported medical schools strengthen their instruction. Allocations under this grant are to be determined by the Trustees after consultation with an advisory group soon to be formed, and will be paid directly to the schools.

"AWARE OF THREAT . . ."

In announcing the grant to the National Fund for Medical Education, Mr. Gaither said, "The Ford Foundation is aware of the critical needs of the nation's medical schools and of the threat to the national welfare posed by their current plight.

"The Foundation hopes that grants under this appropriation will assist the National Fund for Medical Education in its efforts to stimulate the interest and response of the medical profession and of the general public, to the end that financial support for medical schools can be maintained at a level consistent with sound medical education."

Foundation grants will be distributed to the National Fund at the close of each calendar year, starting with 1956.

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*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

1. Karp, M., et al.: Am. J. Obst. & Gynec. 69:780 (April) 1955.

Dr. Elton Clarke Honored by Legion



Receiving a life membership in American Legion Post 6 at Kokomo, Dr. Elton R. Clarke, president-elect of the Indiana State Medical Association, accepts his gold membership card from Frank Meyers, adjutant, Indiana Department of the American Legion.
Reading from left to right are Gene Finley, commander of the Kokomo post, Mr. Meyers, Dr. Clarke, and Claude W. McCoy, post adjutant.

MEMBERS of Howard County Medical Society and members of James DeArmond Golliday Post No. 6, American Legion, joined forces March 31 to honor Dr. Elton R. Clarke, Legion member for 30 years, and president-elect of the Indiana State Medical Association.

At a dinner in the Kokomo Legion home, Dr. Clarke became the eighth life member of the Kokomo post. Life membership is the highest honor a post can award its members.

Dr. John D. Van Nuys, dean of Indiana University School of Medicine, was the principal speaker. He discussed the efforts that have brought the medical profession to its present high status not only in terms of the conquest of disease but in professional qualifications. Indiana's School of Medicine, he said, has the sixth largest student body of all medical schools. He outlined great strides made in medical science in the last 50 years.

Other speakers included Frank Meyers, Legion adjutant, who made the address presenting the life membership to Dr. Clarke; and Dr. Norman R. Booher, Indianapolis, vice-chairman of the American Legion's National Rehabilitation Committee, who said that Dr. Clarke's unselfish service in behalf of veteran rehabilitation as well as his efforts to promote friendly relations between the Legion and the medical profession had been of national importance.

Many distinguished guests, including two brothers of the honored guest, several out-of-state Legion officials; Dr. Lester Bibler, Indianapolis, chairman of the Educational Activities Committee of the Legion Department of Indiana; and James A. Waggener, executive secretary of the Indiana State Medical Association, were introduced.

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Four Indiana Hospital Projects Approved Recently by HEW

The March 31 report of the Department of Health, Education and Welfare on the status of Hill-Burton hospital grants to Indiana communities discloses that four major projects were approved during the month.

The Blackford County Hospital at Hartford City will build a unit providing 20 additional beds at an estimated total cost of $373,182. The federal share is $73,794. Forty-nine beds will be added to the King's Daughters Hospital at Madison at a cost of $1,006,946. The approved federal contribution is $325,649. At South Bend two projects at St. Joseph's Hospital have been approved. Cost of one will be an estimated $3,272,718; the second $328,900. Contributions under the Hill-Burton Act will be $519,736 and $109,633.

Three projects are already under construction, designed to provide 336 additional hospital beds.

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Ames Company and College of Gastroenterology Plan Awards

The American College of Gastroenterology, in cooperation with the Ames Company of Elkhart, Indiana, announces the 1956 Ames Award contest for the best papers on gastroenterology.

Two classes of awards will be made to fellows in gastroenterology, residents, and first or second year interns. The first prize is a $500 cash award, a certificate of merit and a one year subscription to *The American Journal of Gastroenterology*. The second prize includes $250 in cash, a certificate of merit and a year's subscription to *The American Journal of Gastroenterology*.

For the best paper published in *The Journal of Gastroenterology* during the 12 months ending June 30, 1956, for which no prize has been awarded previously, $250 in cash will be paid.

For additional information address: American College of Gastroenterology, 33 West 60th Street, New York 23, New York.

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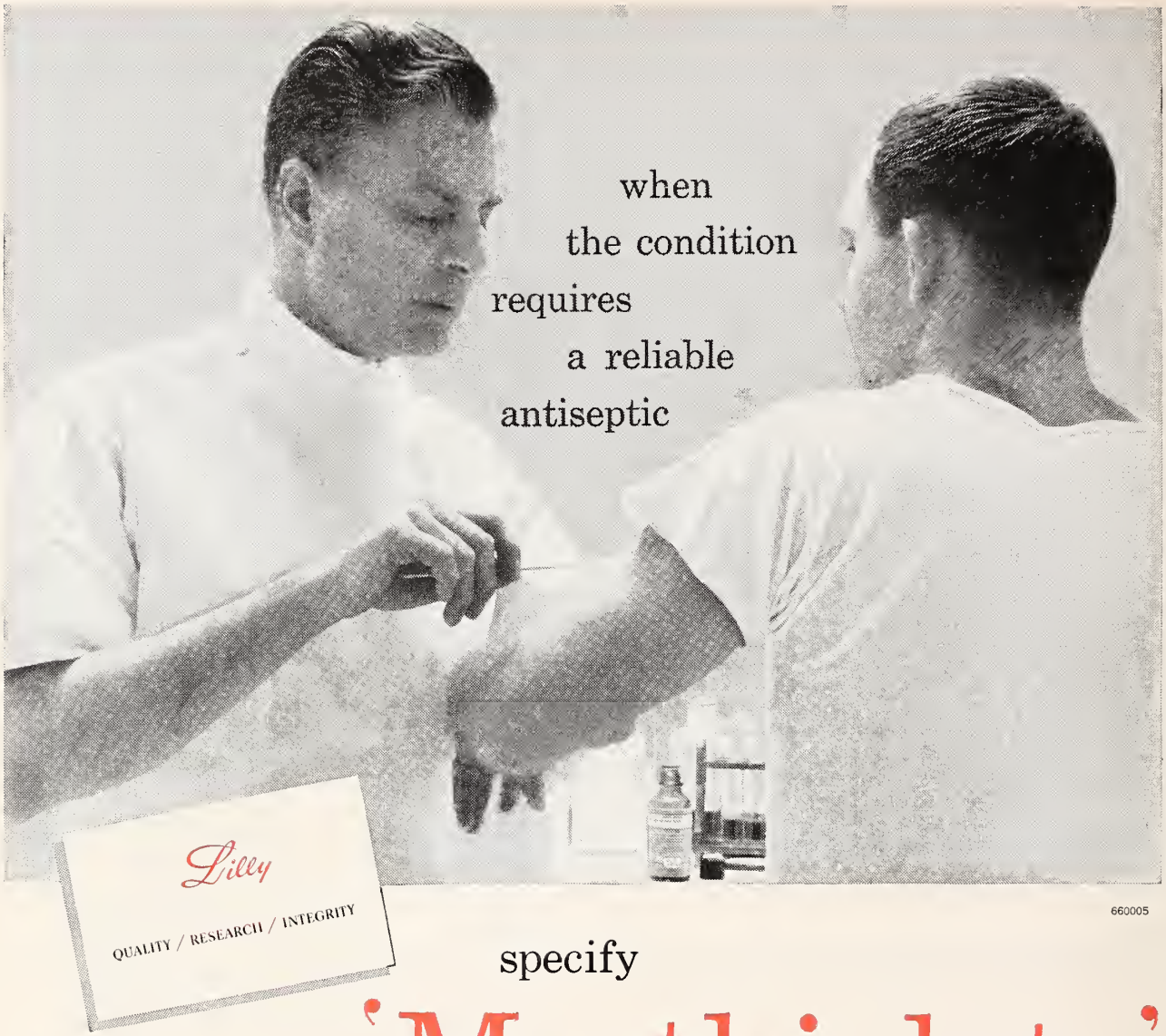
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 49 — June 1956 — Number 6

The Artificial Kidney*

GEORGE T. LUKEMEYER, M.D.†
HUNTER A. SOPER, M.D.‡

Indianapolis

INTRODUCTION:

A MODIFIED Kolff rotating artificial kidney has been employed clinically at the Indiana University Medical Center since July, 1954. A genuine interest in the artificial kidney and the process of hemodialysis on the part of our colleagues and a desire to make the availability of this service more widely known has prompted this report.

Acute renal failure (lower nephron nephrosis, crush syndrome, shock kidney, transfusion kidney, hepatorenal syndrome, burn nephritis, etc.) is a clinical syndrome embracing a large variety of insults to the kidney which result in alterations of renal blood flow and compromise the integrity of the renal tubular epithelium. Acute renal failure is manifested by an abrupt onset with a marked diminution of urine output lasting hours or days, retention of metabolic waste products, electrolyte and acid-base abnormalities, and an eventual diuretic phase with a return of renal function to its approximate previous status.

The artificial kidney does not compete with or replace intelligent conservative management of patients with acute renal failure. There is general agreement among most physicians that hemodialysis for carefully selected patients is an important, and on occasion life saving, adjunct in the medical care of the victims of acute renal failure and/or certain drug intoxications.

II. HISTORICAL BACKGROUND:

The vital role of the kidneys in maintaining the stability of the body's internal environment is well appreciated. An instrument providing for a safe and reliable means of artificially extracting toxic and noxious products from the blood has long been desired. In 1912, Abel, Rowntree and Turner[1] working in their laboratories at the Johns Hopkins Medical School designed and constructed a number of appa-

* This work is supported by the Southwestern Indiana Heart Association and the Indiana Heart Foundation.

† Instructor in Medicine, Indiana University School of Medicine.

‡ Trainee, National Institute of Arthritis and Metabolic Diseases.

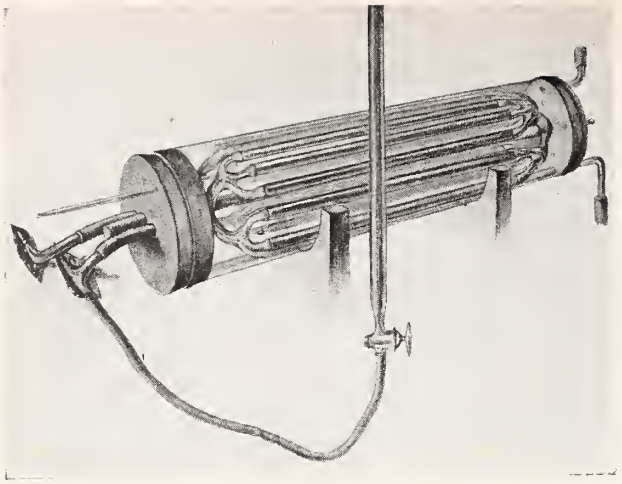


Fig. 1. Reproduction of artificial kidney from the original report of Abel, Rountree, and Turner.

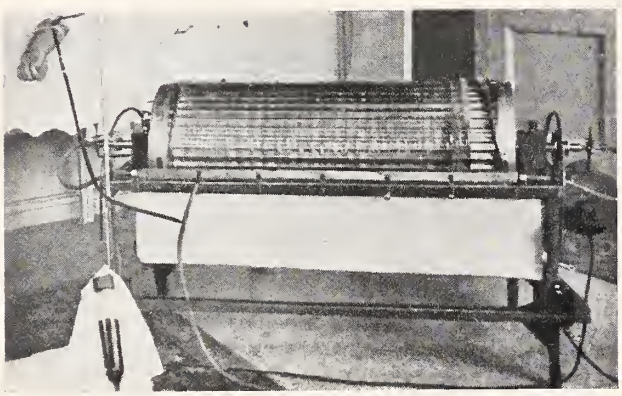


Fig. 2. Front view of first artificial kidney designed by W. J. Kolff, M.D.

ratuses which they called artificial kidneys. Figure 1 is a reproduction of one of their artificial kidneys as it appeared in their original paper.[1] Collodion was utilized as a semi-permeable membrane. With painstaking care these pioneer investigators fabricated collodion tubes with a bore of 6 to 8 mm. diameter and lengths of 20 to 50 centimeters. These delicate tubes were assembled in a variety of patterns and were then suspended within a glass mantle. Blood could be propelled through these collodion channels by arterial tension and returned to the venous circulation. Hypotonic saline solutions were introduced into the glass mantle and bathed the blood filled collodion tubes. Hirudin, tediously extracted from thousands of leech heads, served as their anticoagulant. The blood of large laboratory animals was then circulated through this apparatus and the procedure was called "vividiffusion." This monumental work demonstrated repeatedly that substances such as salicylates and urea could be removed from the animals' blood without disturbing the protein or the formed elements. Unfortunately their anticoagulant was not safe for use in humans.

No further reports regarding the artificial kidney were forthcoming from Abel, Rowntree and Turner and more than 30 years passed without any significant contributions in this field. The efforts of Abel, et al. made it obvious that in order to pursue this line of endeavor an efficient, easily acquired dialysing membrane, and a safe anticoagulant were necessary. W. J. Kolff, a Dutch physician, working under the adverse conditions of the German occupation, designed and perfected what must be regarded as the first clinically successful artificial kidney. In 1947 he published a detailed account of his experience and gave a careful description of his machine.[2] Figure 2 is a picture of one of his early artificial kidneys. It was Kolff who carefully reviewed the original work of Abel, Rowntree and Turner and then stated that "an ideal vividialysis must fulfill the following demands:

1. The blood must be kept in a closed system outside the body;
2. It must be possible to sterilize this system;
3. The dialysing area must be as large as and the volume of the system as small as possible;
4. The blood must be kept liquid in a harmless way."[2]

Independently and almost concomitantly Murray in Canada and Alwall in Sweden also designed and constructed artificial kidneys. The late Dr. J. C. Manning and Dr. F. W. Taylor[3] of the Surgery Department of the Indiana University School of Medicine became interested in dialysis and constructed an artificial kidney in the middle 1940's. Their machine was utilized clinically and was described in a preliminary report published in 1948. Figure 3 is a schematic drawing of their artificial kidney as it was presented in their original publication.

Subsequently a number of artificial kidneys of varying design have been introduced. The Skeggs-Leonard unit was introduced about 1948. This artificial kidney is so constructed that it can be used for ultrafiltration as well as dialysis. The Kolff rotating artificial kidney has had a number of improvements and modifications and

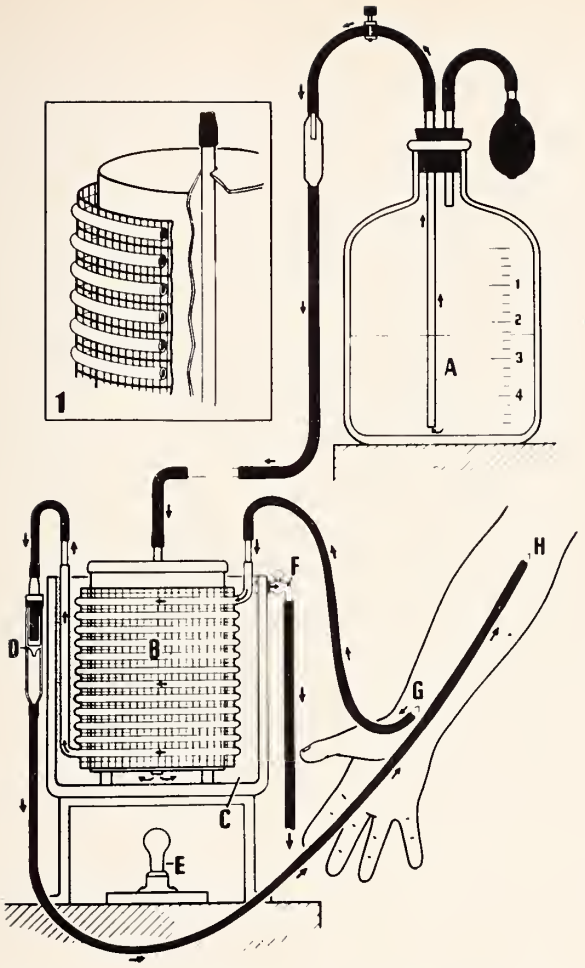


Fig. 3. Schematic drawing of artificial kidney used by Manning and Taylor. A-bath solution, B-cellophane tubing wrapped around drum, C-solution bathing cellophane tubing, D-clot remover, E-heat source, F-drain for bathing solution, G-arterial cutdown, H-venous cutdown. Path of blood indicated by the arrows.

it is this machine that will be primarily considered in this report.

III. PRINCIPLES OF THE ARTIFICIAL KIDNEY:

Essentially the same basic principles are employed in the various types of artificial kidneys in use today. "Blood is either withdrawn with a pump from a large vein or taken from an artery and guided through a system of dialyzing membranes (tubes or sheets) with blood on one side and the rinsing fluid on the other side."[4] Cellophane is the semipermeable membrane which is used almost exclusively. Diffusion can then occur with small molecules crossing the membrane in both directions depending upon their concentrations and relative pressure gradients. The smallest of viruses (e.g. foot and mouth disease and poliomyelitis) are slightly larger than a molecule of serum globulin and therefore cannot penetrate the cellophane. It should be emphasized that crystalloids will move in both directions across the cellophane barrier. This is schematically illustrated in figure 4 wherein a high blood concentration electrolyte such as potassium moves from the blood into the rinsing solution while sodium is shown moving through the cellophane from the rinsing bath into the blood.

Hemodialysis can therefore be defined as a process of purification of the blood by diffusion of crystalloids across a semipermeable membrane. It is indeed fortunate that electrolytes; "all known retention products (of protein breakdown) such as urea, uric acid, creatinine, and phenols, are able to pass through the membrane."[4] Salicylate, thiocyanate, bromide and some barbiturates will also diffuse across the cellophane barrier. Obviously the rinsing fluid must either be changed continuously or be of a sufficiently large volume to prevent equilibration and back diffusion. The concentration differences between the rinsing fluid and the blood to a large extent determine the diffusion gradients and with careful preparation of the rinsing solution the various small molecules can be selectively

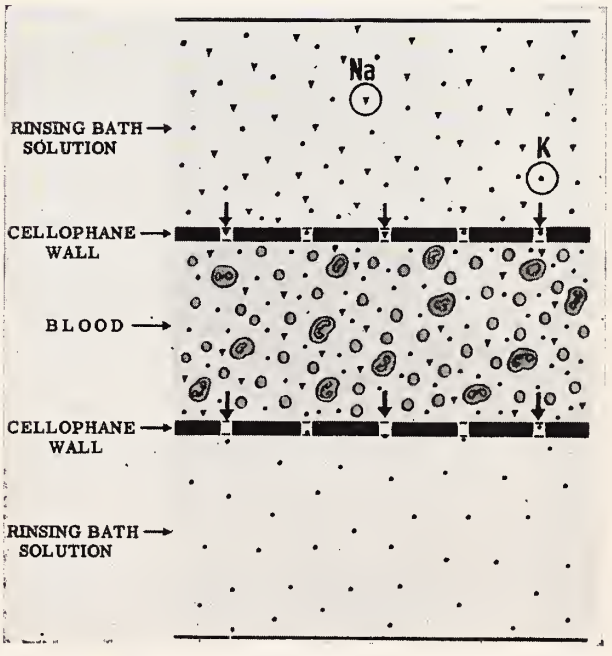


Fig. 4. Schematic cross-section of cellophane membrane. The membrane is porous allowing small molecules to pass through it. Bacteria, viruses and serum proteins cannot penetrate it. Diffusion is presented as electrolytes crossing the cellophane in both directions.

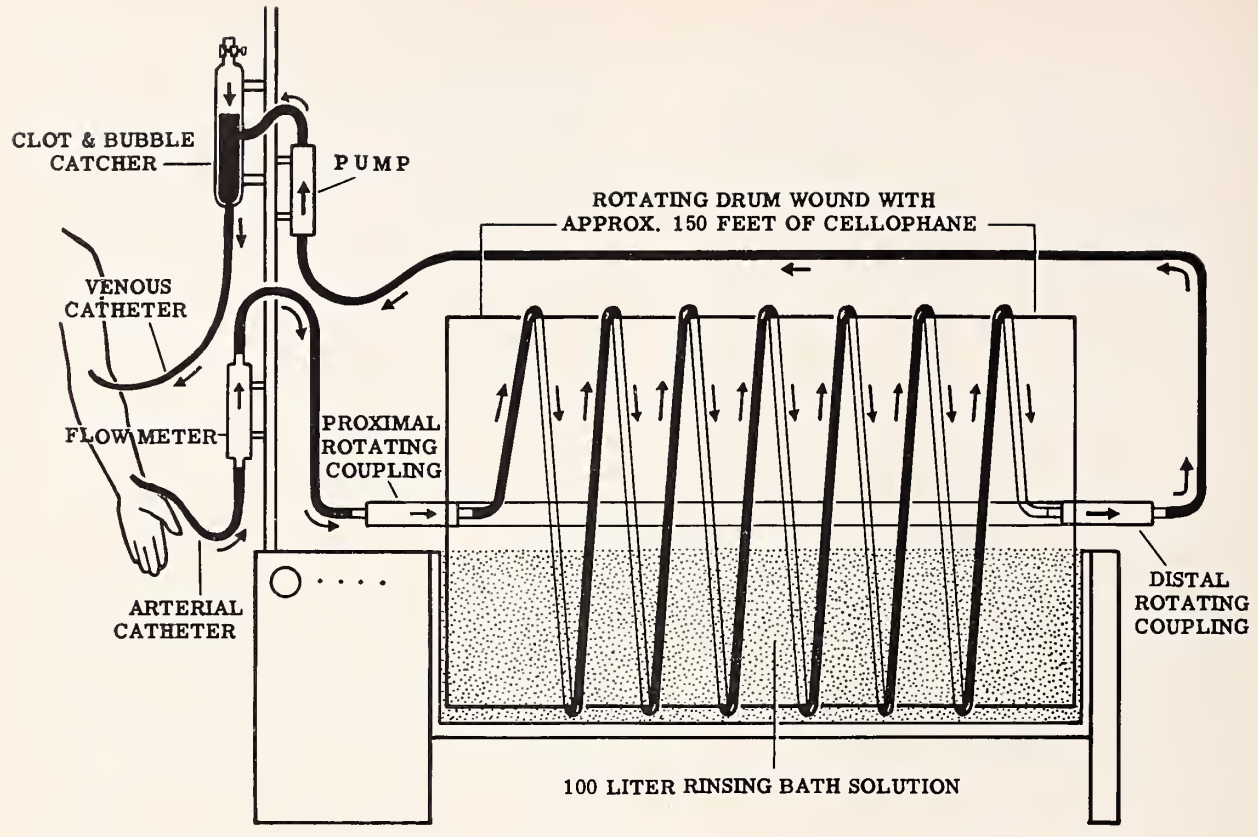


Fig. 5. Schematic drawing of modified Kolff artificial kidney now in use at Indiana University Medical Center. Arrows indicate the course of the blood as it flows from the radial artery to the antecubital vein.

removed or added to the blood stream as the process of hemodialysis is accomplished.

Water movement across the membrane is controlled by hydrostatic force as the rinsing fluid is compounded so as to be isosmolar with the blood. In the Kolff type artificial kidney there is a very low hydrostatic pressure in the cellophane loops and, thus, there is a negligible amount of water passing from the blood into the rinsing bath. When desired the rinsing fluid can be made hypertonic by the addition of large amounts of dextrose and in this manner some fluid can be withdrawn from the overhydrated patient.

IV. DESCRIPTION OF MODIFIED KOLFF ARTIFICIAL KIDNEY:

The modified Kolff rotating artificial kidney is a large mechanically simple apparatus which has been proven by extensive use to be an efficient and safe unit for hemodialysis. A schematic drawing of the artificial kidney currently in use at the Indiana University Medical Center is illustrated in figure 5. Blood is propelled by arterial tension from a radial artery via a polyvinyl plastic cannula through a simple rotameter type flowmeter and thence on through the proximal rotating coupling to the first loop of cellophane. Approximately 150 feet of 23/32″ lay-flat diameter cellophane tubing is wound spirally about the stainless steel wire mesh rotating drum. This drum measures 36″ in width and 18″ in diameter. The column of blood moves from left to right through the cellophane tubing according to the Archimedian screw principle. As the drum revolves about its long axis approximately 40% of its lower surface is immersed in the rinsing solution. A "pump" with alternating negative and positive pressure pulls the blood from the terminal cellophane loop through the distal rotating coupling into a polyvinyl plastic tube. The column of blood is then directed around the back of the machine and forced up into a distensible plastic "clot and bubble catcher" reservoir. This device allows air bubbles to escape harmlessly and prevents any

small blood clots from being returned to the patient's venous circulation. The blood level in the expansile "clot and bubble catcher" is an indicator of the rate of venous return to the patient and the cushion of air above the blood provides gentle positive pressure facilitating the return of blood to the patient. As implied above the blood flows from the clot and bubble catcher via a plastic cannula into a large peripheral vein of the patient.

The rinsing solution is kept at a constant temperature of 100° to 101°F by means of a thermostatically controlled heating element in the floor of the bath. It is our practice to change the rinsing bath solution either on the hour or at two hour intervals in order to maintain an efficient diffusion gradient. The bath contains 100 liters of rinsing fluid. Table No. 1 presents the composition of the standard rinsing solution. All of the chemicals with the exception of the $CaCl_2$ are added to tap water as the solution is prepared with the tub in the "down position" (Fig. 6). The electrolyte content of tap water is not of enough significance to make the use of distilled water a necessity. At this point the bath fluid is markedly alkaline and $CaCl_2$ would not remain in solution. With the lucite hood in the "closed position" (Fig. 7) the tub is elevated and as the rinsing fluid covers the lower edge of the lucite hood a water seal is established. A mixture of 10% CO_2 and 90% O_2 is introduced through a vent in the lucite hood at a rate of 15 liters per minute for the first 10 minutes. The delivery rate is then reduced to 2 liters per minute for the remainder of the use of that particular bath. The

TABLE 1. STANDARD RINSING BATH COMPOSITION

100 Liters of Tap Water	Grams	Mos/L	Meq/L
NaCl	660	226	113
$NaHCO_3$	225	54	26.8
KCl	30	8.0	4.0
$MgCl_2.6H_2O$	10	1.5	1.0
$CaCl_2.2H_2O$	18.5	3.8	2.5
Dextrose	200	10	
		303.3	

$Na+ = 140$
$Cl- = 120$

$CaCl_2$ is added 10 minutes later as the CO_2 and O_2 atmosphere, with the agitation of the revolving drum, brings the rinsing fluid to a pH of approximately 7.4. This allows the addition of the calcium without precipitation of calcium salts. The lucite hood cannot be opened during the dialysis as the bath would become more alkaline, resulting in the precipitation of calcium salts.

V. TECHNIQUE OF DIALYSIS:

The artificial kidney is kept in a special large air conditioned room. All patients are brought to this location for dialysis. It is our feeling that the need for ancillary equipment, supplies and special facilities warrants a particular room

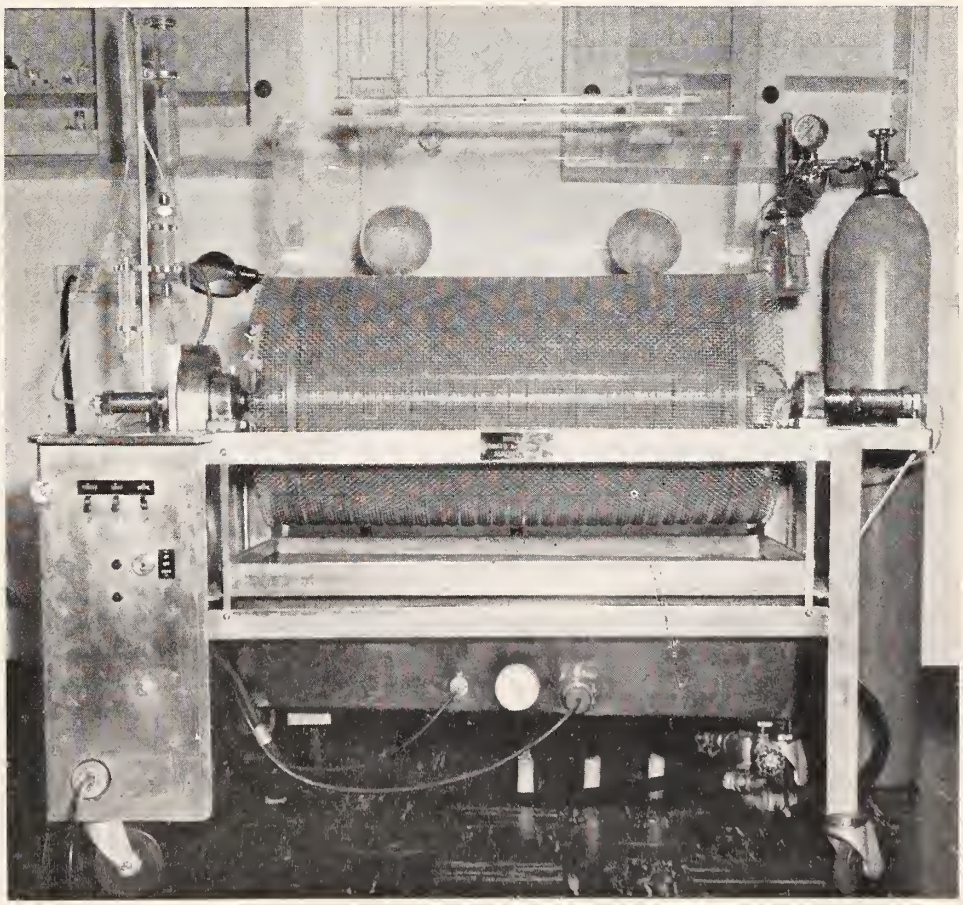


Fig. 6. The artificial kidney with the tub in the "down position" and the lucite hood in the "open position".

to house the artificial kidney. A team composed of two physicians, one technician and a nurse are required for each dialysis.

The cellophane tubing is wrapped on a special reel and sterilized by boiling it for 30 minutes. The filling burette, rotating couplings, clot and bubble catcher and polyvinyl plastic tubes are sterilized by autoclaving them. The flow meter is soaked in 1:1000 benzalkonium chloride solution for 18 hours. It takes approximately 60 to 90 minutes to assemble the machine. The artificial kidney with the lucite hood in the "open position" and the tub in the "down position" is shown in figure 6. The attachments can be identified easily by referring to the schematic drawing presented in figure 5. Figure 7 shows the machine with the hood in the "closed position" and the tub in the "up position." The cellophane tubing is now filled with sterile saline and the loops are inspected for evidence of any gross leaks. This is done with the tub in the "down position" and the lucite hood open. Following this, 50 milliliters of blood diluted with 300 milliliters of sterile normal saline is allowed to fill the cellophane loops. A liberal amount of sterile distilled water is then poured over the cellophane loops while the rotating drum is slowly turned. If there are any minute leaks in the cellophane the red blood cells will be hemolyzed and the water dripping from the cellophane loops into the lowered bath will have a pink discoloration. Should there be any leaks the faulty section of cellophane tubing must be removed and replaced with a tygon plastic tube splice or the drum must be wrapped again with fresh cellophane and the testing for defects repeated. Once the integrity of the cellophane has been established, the system is cleansed by flushing 10 liters of normal saline through the tubing. The rinsing bath solution is now prepared and the system is primed by filling it with approximately 600 milliliters of fresh, carefully cross-matched blood.

While the above measures are in progress the patient arrives at the artificial kidney laboratory and the surgeon prepares to cannulate a radial artery and a large vein. Under local anesthesia the radial artery is exposed. Next a large vein (usually an antecubital vein) is exposed, cannulated and 100 mgm. of heparin is injected intravenously. Heparinization is essential and heparin adequately fulfills Kolff's requirement of a relatively harmless way to keep the blood in a liquid state. The artery is now cannulated and the patient has now been made ready for dialysis. The arterial and venous cannulae are attached respectively to the proximal and distal plastic tubes of the artificial kidney. The arterial and venous clamps are removed simultaneously and blood leaves and enters the patient instantaneously. This is a critical period and blood pressure determinations are taken every 30 seconds and a previously selected lead of the electrocardiogram is obtained every few minutes. A balance between the inflow and outflow of blood from the machine is obtained by the use of calibrated screw clamps on the arterial and venous cannulae. Once an adequate inflow (200 milliliters or more of blood per minute) and return rate to the patient are established the blood pressures are taken every 5 to 10 minutes and the entire dialysis is monitored by frequent electrocardiograms. Once the proper balance of blood flow has been achieved the flowmeter reads at a constant level, there is no cellophane loop distension and the blood level in the clot and bubble catcher remains constant. The usual dialysis is continued for six hours although it can be terminated at any desired time. The rinsing bath solution, as previously stated, is changed every two hours and in some instances at hourly intervals. The bath solution is watched constantly for any evidence of blood loss into the fluid. Hematocrits are obtained at one hour intervals in order to detect any evidence of intravascular hemolysis. Blood chemistries and electrolyte determinations are made as frequently as deemed necessary. Heparin is administered in 10 mgm. amounts intravenously at hourly intervals. Throughout the procedure the nurse provides whatever nursing care is needed by the patient.

The problems of hemodialysis are numerous. An adequate flow of blood is mandatory. There are the complications of bleeding and/or clotting to be reckoned with. The cellophane loops are distensible and if there is an obstruction at the distal end of the circuit bleeding into the machine results in exsanguination. The opposite complication is likewise possible and if there is a block on the arterial side preventing blood from entering the machine, then the blood that has been used to prime the system can be injected

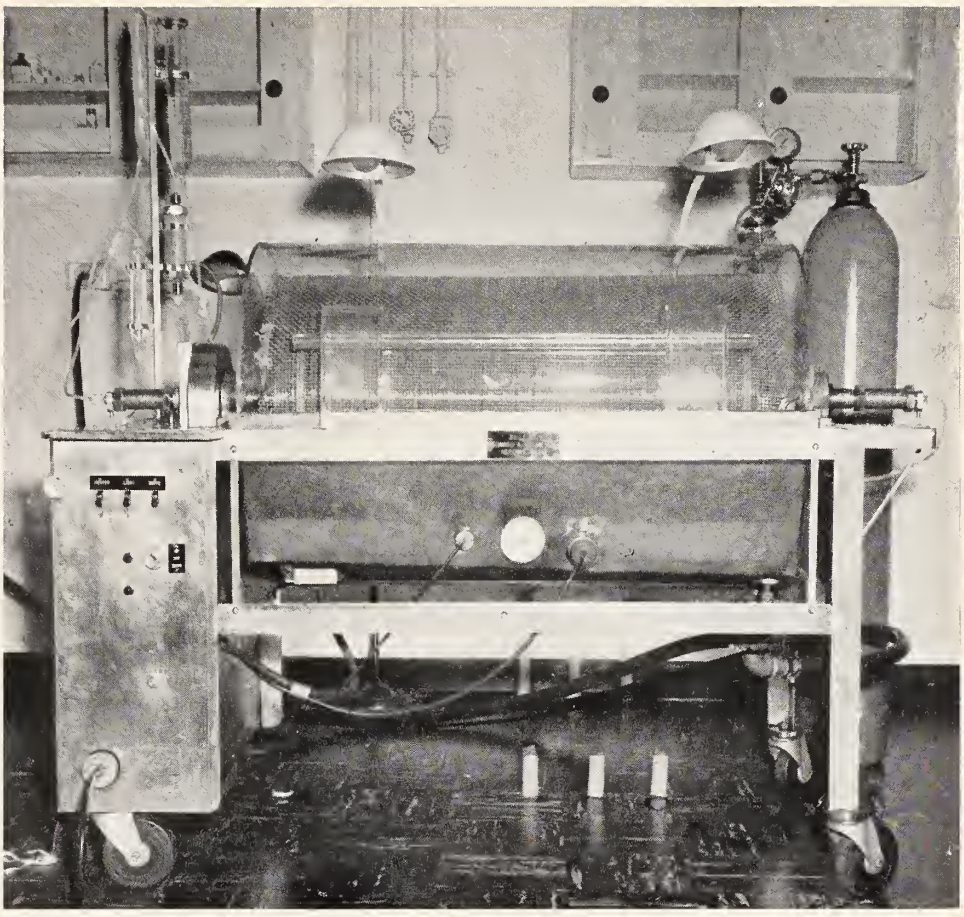


Fig. 7. The artificial kidney with the tub in the "up position" and the lucite hood in the "closed position".

into the patient and plethora rapidly produced. The problems of electrolyte, water and acid-base balance are ever present. Sepsis must be avoided by adequate sterilization of equipment and careful technique in assembling the artificial kidney and in conducting the dialysis. "The mechanical ability required to assemble and operate this apparatus clinically is not great and can be acquired in a few weeks. The knowledge of cardiorenal disease required to decide when the procedure can be usefully applied is, of course, far less readily acquired."[5]

VI. OUR EXPERIENCE:

It has been our privilege to see 50 patients as candidates for hemodialysis since the artificial kidney has been available clinically. Nineteen patients have had a total of 25 dialyses with 13 patients having 1 dialysis and 6 receiving 2 dialyses. Thirty-two of this group of 50 patients were regarded as having acute renal insufficiency. The patients with acute renal insufficiency varied considerably in age, severity of disease, and precipitating factors for the kidney shutdown. In this group of 32 patients, 10 of the most seriously ill were subjected to hemodialysis. Four of these patients eventually recovered and six ultimately expired. The remaining 22 patients in this group with acute renal insufficiency included those less seriously ill on the one hand and the hopelessly ill on the other hand. In this group there were 13 recoveries and 9 deaths. Not infrequently the seriousness of the condition precipitating the acute renal failure played a major role in the demise of the patient. Four patients with "chronic renal disease" were treated with hemodialysis. In this group one nine-year-old boy had a gratifying relief of his uremic symptoms for about one month. All eventually succumbed to their illness. We have had one death during dialysis and this occurred in a 75-year-old man with chronic pyelonephritis in whom dialysis was attempted to prolong his life. The patient was moribund and died 20 minutes after the start of dialysis. This occurred early in our use of the artificial kidney and as our experience has increased we now recognize that this patient with irreversible kidney damage and so desperately ill was not a suitable candidate for dialysis. Two patients with subacute glomerulonephritis were dialyzed two times each. We were unable to establish with certainty the nature of their kidney failure during life. In one patient a question of benzene poisoning was present and in the other there was a possibility of a toxic reaction to an antirheumatic drug. Post-mortem studies established the diagnosis in each instance. One of the patients, a girl of 19, had attempted to commit suicide by taking over 100 60 mgm. tablets of phenobarbital. With a six-hour dialysis we were able to remove from her and recover in the rins-

TABLE NO. 2

CONDITIONS IN WHICH HEMODIALYSIS MAY BE INDICATED

I. Acute Reversible Uremia
 A. Acute renal failure (embracing such entities as:)
 1. Lower nephron nephrosis
 2. Acute renal tubular failure
 3. Acute tubular necrosis
 4. Shock kidney
 5. Traumatic uremia
 6. Transfusion kidney
 7. Crush syndrome
 8. Hepato-renal syndrome
 9. Toxic nephrosis
 10. Burn nephritis
 11. Acute parenchymatous degeneration
 B. Acute renal failure due to nephrotoxic agents
 1. Carbon tetrachloride
 2. Mercury bichloride
 3. Mushroom poisoning
 4. Diethylene glycol
 5. Potassium bichromate
 6. Uranyl nitrate
 7. Sodium potassium tartrate
 8. Potassium chlorate
 9. Sulfonamides
 C. Anuria in the late stages of severe acute glomerulonephritis

II. Intoxications Without Primary Nephrotoxic Actions
 A. Bromides—(artificial kidney very efficient for removal of bromide as it can selectively remove this halide)
 B. Salicylates
 C. Barbiturates:
 1. Phenobarbital dialyzable
 2. Pentobarbital (nembutal) slightly dialyzable
 3. Secobarbital (seconal) and amybarbital (amytal) are practically undialyzable as they are bound to proteins.

III. Dialysis as a Pre-Operative or Post-Operative Measure (Especially when surgery is directed at correcting or alleviating the condition responsible for the urinary suppression.)
 A. Bilateral obstruction of ureters
 1. Calculi
 2. Strictures
 3. Blood clots
 4. Neoplastic obstruction
 B. Obstruction at bladder neck
 1. Prostatic obstruction
 2. Stricture of the urethra
 3. Vesical calculus

IV. Chronic Uremia
 A. Acute exacerbation of chronic uremia. (It is sometimes possible to restore delicate state of equilibrium so that a useful life is possible despite persisting chronic renal insufficiency.)
 B. Chronic uremia. (Some investigators feel that patients with chronic uremia are entitled to at least one dialysis as remissions may occasionally last for several months.)

V. Contra-Indications: The one absolute contra-indication is uncontrolled bleeding.

ing bath solutions a total of 4,040 mgm. of phenobarbital. The girl eventually made a complete recovery. A young man of 16, in the terminal stages of acute glomerulonephritis had two dialyses in a futile attempt to save his life.

It can be seen from this brief resume of our experience that it is too limited to make any definitive statements indicating when the artificial kidney should or should not be used. Table No. 2, developed from the reports of many established investigators, summarizes the indications and contraindications for hemodialysis.

VII. SUMMARY:

The artificial kidney is an important aid in the conservative management of selected patients with acute renal failure. The historical development and some of the basic principles of the apparatus have been presented. An attempt has been made to describe the modified Kolff rotating artificial kidney now in use at the Indiana University Medical Center. Mention has been made of some of the problems encountered by those engaged in hemodialysis. A short resume of our experience has been given. An outline of the indications and contraindications for hemodialysis has been included in this report.

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A Method of Preparing a Pedunculated Flap with Maximum Vascularity and Resistance to Infection

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THERE ARE NUMEROUS LESIONS which occur about the body that involve loss not only of skin, but subcutaneous tissue as well. These defects require more than a free skin graft to obtain resilient and elastic tissues for repair and restoration of contour. The restoration of this type of defect is dependent on the use of a pedunculated flap.

Since publication of the first systematic treatise on plastic surgery in 1597,[1] numerous plastic surgeons have devised and reported means for creating more durable pedunculated flaps. Further impetus was given toward this end by the problems caused as a result of the injuries incurred in the two recent world wars.

A valuable contribution was made by experimental work on the development of circulation in flaps by German, Finesilver and Davis (1933).[2] Further progress was demonstrated by Hynes (1950),[3] and Braithwaite (1951).[4] The arterial vascularization of pedicle flaps has recently been investigated by Conway, Stark, and Nieto-Cano (1953).[5]

We are about to describe a technique for the preparation of pedunculated flaps, which, in our experience, has been found to be most effective in the treatment of certain types of defects. This procedure is undoubtedly in use by many who are practicing plastic surgery. We have not, however, found the method described in the literature. We feel that a description of the method may be of value to those who have not utilized this procedure in cases where it might be indicated.

The procedure we are about to describe is of special value in constructing pedicle flaps to be used in the repair of chronic ulcers and over areas of exposed bone. This method, when properly utilized, produces a sturdy flap with a completely independent blood supply and maximum resistance to infection. According to our technique, the flap is outlined in healthy tissue adjacent to the defect whenever possible, thus utilizing a permanent pedicle flap as advocated by Brown, Fryer, and McDowell.[6]

When adjacent tissue of a suitable nature is not available, some type of remote flap is developed. In either case the following procedure is carried out.

TECHNIQUE OF PROCEDURE

The flap is outlined on the donor area. In most cases the distal end of the flap is not completely severed at this stage. The flap is undermined and careful hemostasis is obtained. An intermediate split thickness graft is placed under the flap. The epithelial surface of the graft is in contact with the subcutaneous portion of the flap. It is sutured in such a fashion as to cover the base, but not the lateral walls of the donor site of the flap. Thus the flap can be sutured back into the original position over the graft and still permit healing of the flap edges. The primary

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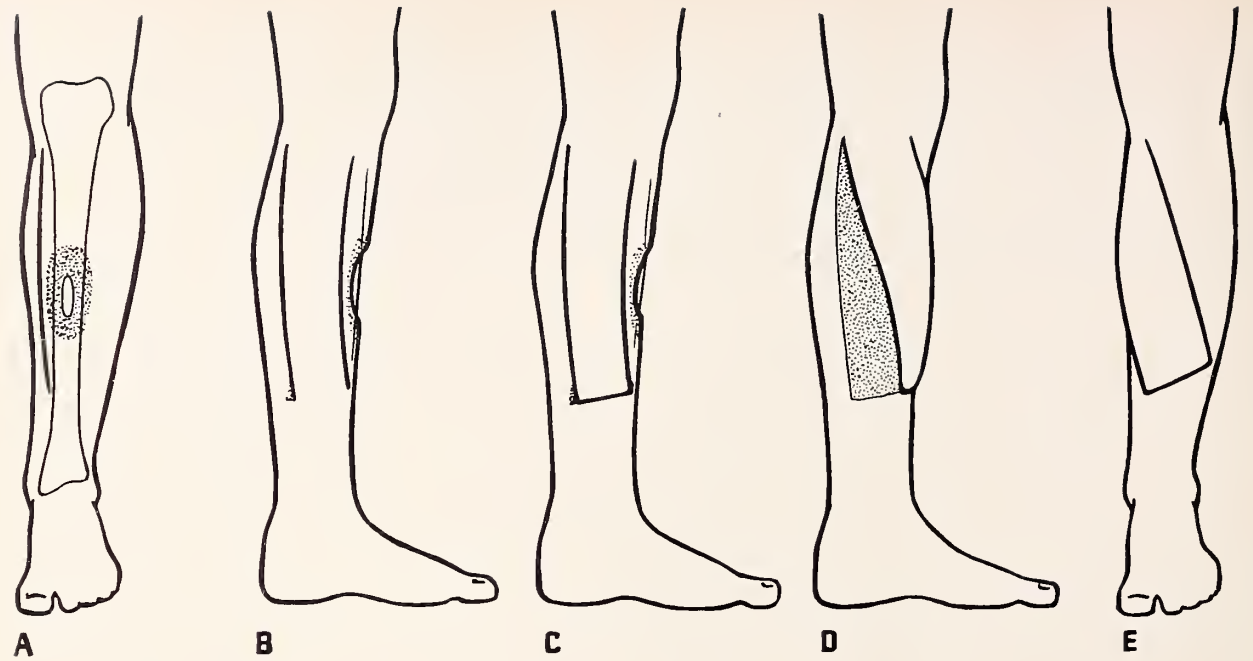


Figure 1. Diagramatic description of the technique described:

A. Represents an osseous defect due to osteomyelitis previously covered by a split graft which is ulcerated, exposing bone.

B. Outline of an adjacent flap in healthy tissue on the medial aspect of the leg. The distal end of the pedicle is intact. The intermediate split thickness skin graft is implanted under the flap as described in the text and the graft is shown sutured to the skin surface at the dependent angles of the flap to provide drainage. The exposed graft demonstrated by the stippled area on the diagram.

C. Demonstrates the severence of the distal portion of the flap.

D. Illustrates the medial view of the leg following rotation of the flap after sequestrectomy of the devitalized bone and attachment of the flap to the healed graft which was initially placed under the flap.

E. Illustrates the anterior view of the leg following the rotation of the flap which covers the original defect.

healing of the cut edges of the flap prevents excessive scarring and contracture of the flap.

It is important to allow for adequate drainage from the area beneath the flap. In order to provide for this requirement, we find it most practical to suture the implanted graft to the skin surface at the dependent angles of the flap as shown in the diagram. This creates a channel which allows free drainage from under the flap. The drainage is due to the fact that the subcutaneous surface of the flap is in contact with the epithelial surface of the graft. If provision for this drainage is not adequate, there is the almost certain risk of formation of a seroma which may become infected. This complication may cause loss of the graft and perhaps loss of a portion of the flap. A good take of the graft is the rule, provided hemostasis is accomplished. The take of the graft insures an independent blood supply in the flap.

In 10 to 14 days the distal end of the flap is severed without disturbing the lateral attachments of the flap. One week later the entire flap is elevated and rotated over the defect. Before the flap is transferred, it is important to remove excessive granulations and scar from under the subcutaneous surface of the flap. It is at this time that the final debridement of the recipient area is completed.

The flap is then sutured into position and to the edge of the healed graft which was originally inserted beneath it.

It is our impression that this technique has definite advantages for a number of reasons. The



Figure 2.

A. A sixteen year old boy with a history of chronic osteomyelitis of the left tibia for nine years. This area has been previously healed with a split graft. It has been recurrently broken down due to reactivation of the bone disease.

B. An adjacent flap was raised, by the technique we have described.

C. And the defect healed in three operations.

D., E., F.: Photographs taken 18 months after the repair of the defect.

circulation of the flap is limited completely to the pedicle supply by virtue of the healed skin graft which underlies the flap. The contact of the subcutaneous tissues of the flap with the epithelial surface of the graft produces a layer of granulation tissue which has increased resistance to infection.

SUMMARY

There have been many reports of multiple stage procedures employed in preparing pedunculated flaps for use in reconstruction of surface defects.

The procedure we have described is of special value in constructing pedunculated flaps to be used in covering chronic ulcers and over areas of exposed bone. This method, when properly utilized, produces a sturdy flap with a completely independent blood supply and maximum resistance to infection.

It should be obvious that this technique will not develop blood supply in an area where there is none. This flap, like all others, must be developed in healthy tissue. Furthermore, it should be apparent that in the delay procedure the time element is important. The times quoted in the text are minimum. We wish to state, however, that prolonged intervals between stages are to be avoided, in order to prevent excessive





Figure 3. Sixty year old male with a large scalp and skull defect secondary to radiation therapy of an epidermoid carcinoma of the scalp. The multiple sebaceous cysts of the scalp were excised prior to the treatment of the defect demonstrated. The ulcer was excised and the wound failed to granulate due to devitalized bone. A large scalp flap was raised and a split graft implanted. Debridement of the devitalized bone was accomplished by removal of the outer table of the skull and the flap was rotated over the defect. Complete repair required only two operations.

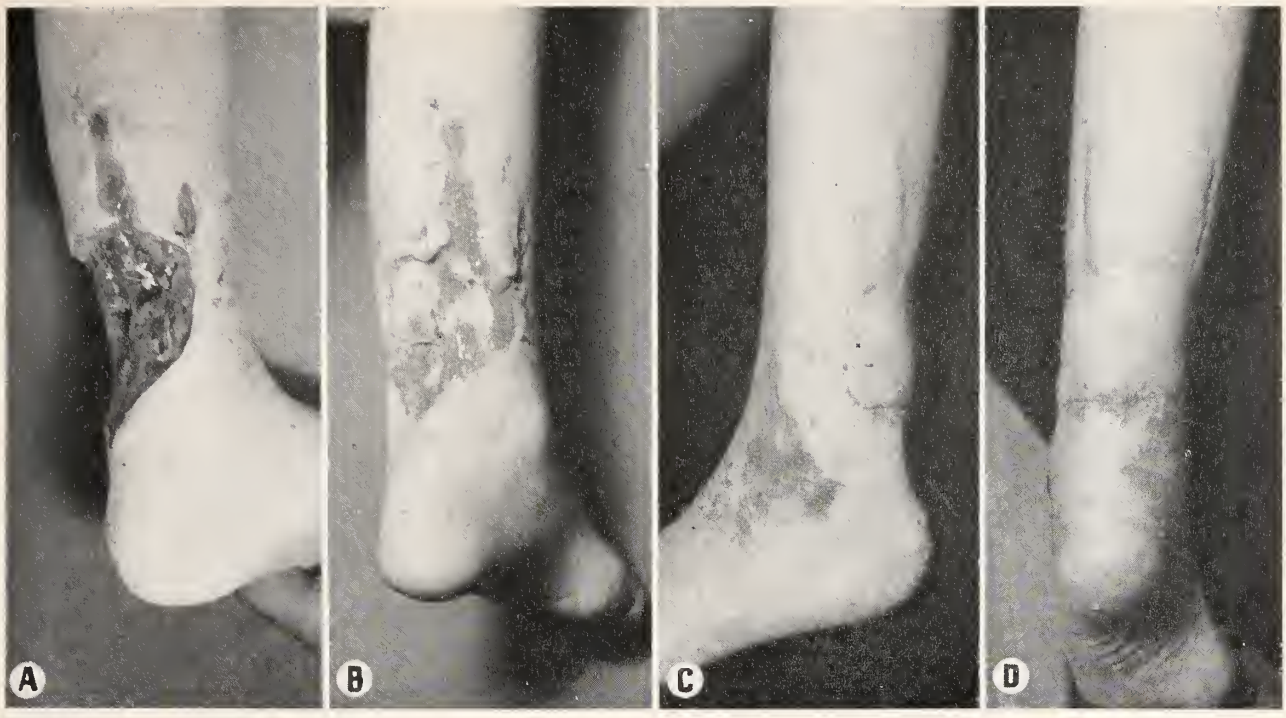


Figure 4. Six year old boy with extensive injuries to the posterior aspect of the left ankle and almost complete loss of the Achilles tendon. Initial defect 4 x 2½ inches with a necrotic base. A flap was raised on the right thigh, a split thickness skin graft implanted as a delay procedure and the flap was transferred by the cross-leg technique in 4 operations.

contracture of the flap due to fibrosis and scarring.

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Hip Fractures:

PRESENT STATUS OF THE PROBLEM

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NOT TOO MANY years ago, fractures of the hip were classed as "the unsolved fracture". Many of the problems, that were so troublesome at that time, have been relatively solved now, but we still have many difficulties in connection with these cases.

It appears to this writer that here is one of the finest illustrations of the value of collaboration between the internist and the surgeon, in that good results are dependent upon full cooperation in each individual case.

The first problem of course is the matter of age. Nearly all these patients are in the older age group, many of them with arteriosclerosis and cardiac disturbances, with or without renal complications and urinary tract infections.

All these conditions must be cared for in addition to the main problem in a medical manner appropriate to the situation. Many of these patients have added factors such as cystoceles, hemorrhoids, or enlarged prostates. Elderly women are usually dehydrated, because over a period of years they have not drunk enough water. Many of them have diverticulosis or diverticulitis of the colon. Some of them are prone to have bowel impaction and a good many will not drink enough milk to keep the calcium and phosphorus intake up to a normal level.

In addition they may be in a state of poor nutrition as regards the protein and amino acid content of their diets. A fair number have anemias which are mostly hypochromic. Gastric achlorhydria, and vitamin deficiencies are frequently found. All of these medical factors are to be taken into account and it is obvious that the complexity and number of them is sufficient

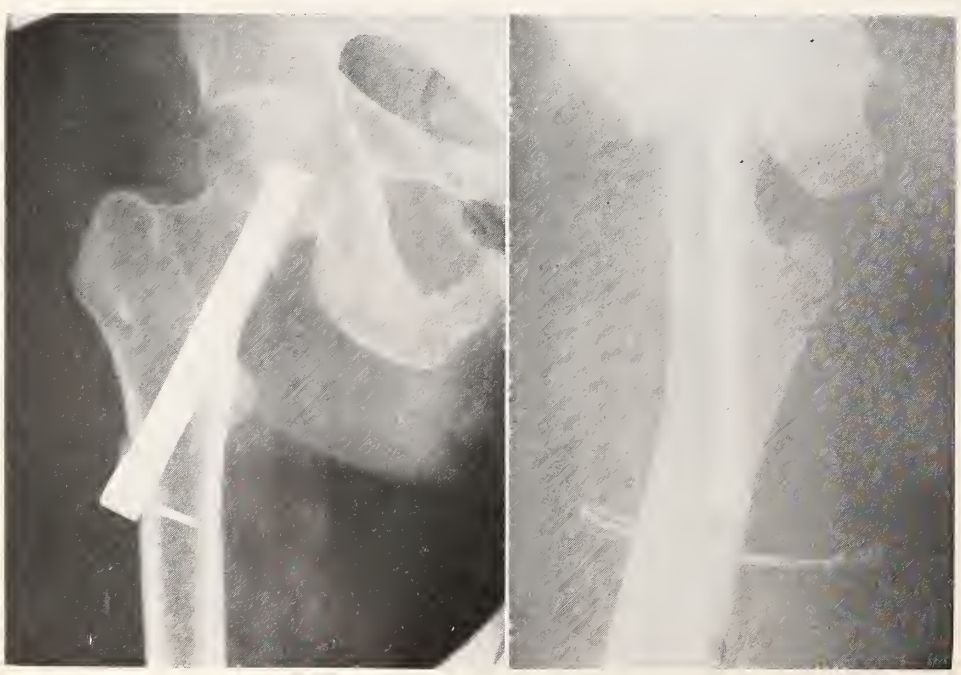
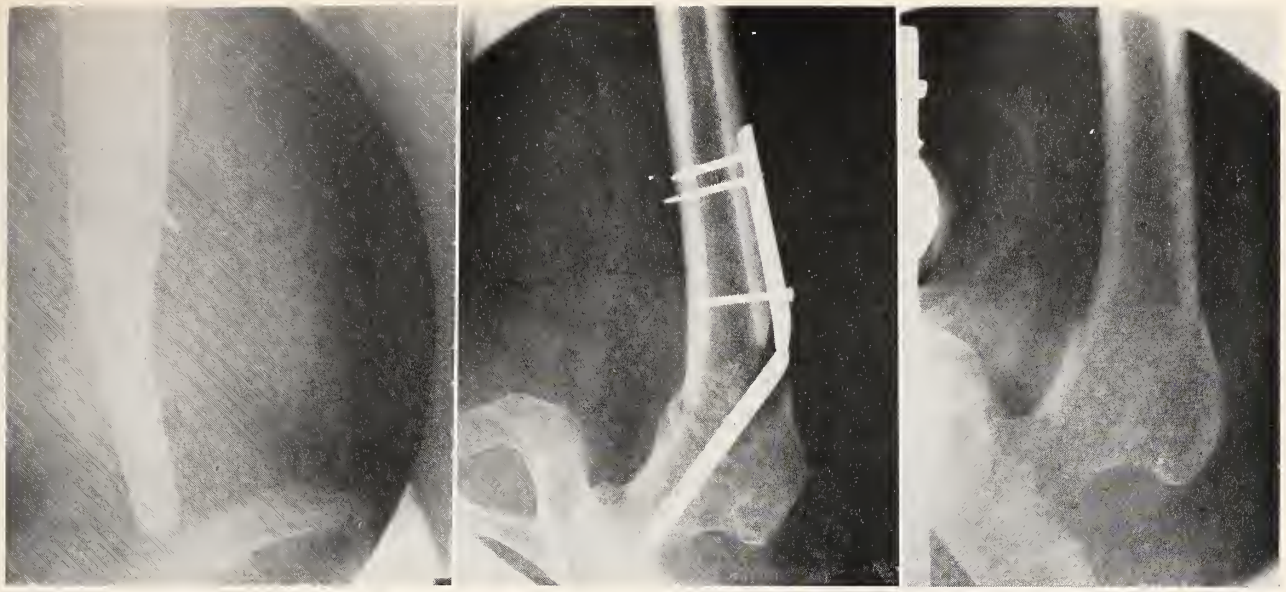


Figure 1. Case I, female, age 82, high cervical fracture, AP view after reduction and fixation with Smith-Peterson nail. Right, Case I, lateral view.



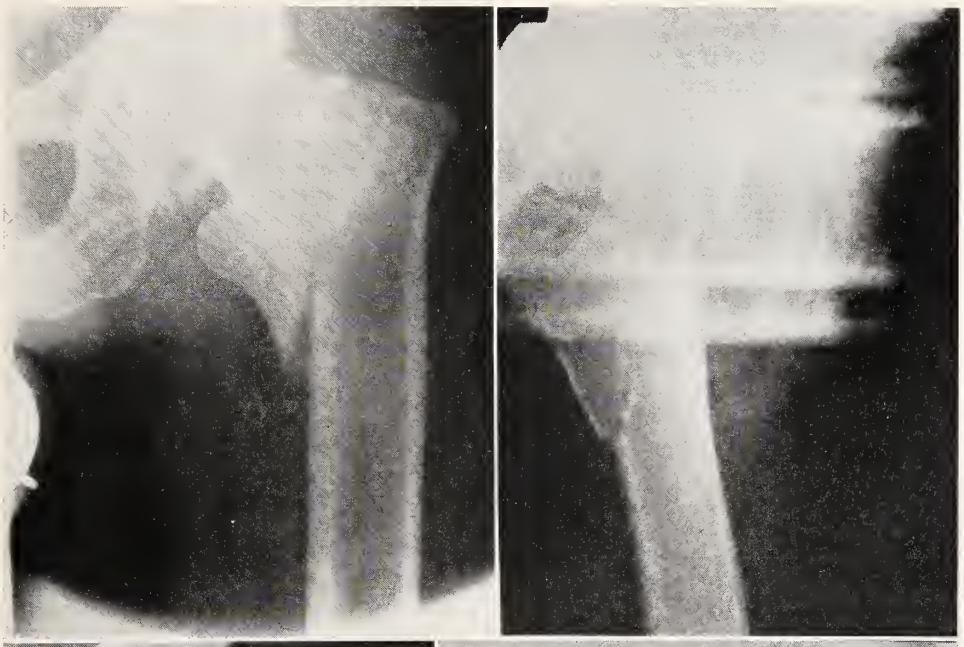


Figure 2a. Case II: lower cervical and trochanteric fracture, before fixation. Center, AP view after repair with Neufeld plate. Right, lateral view after repair.

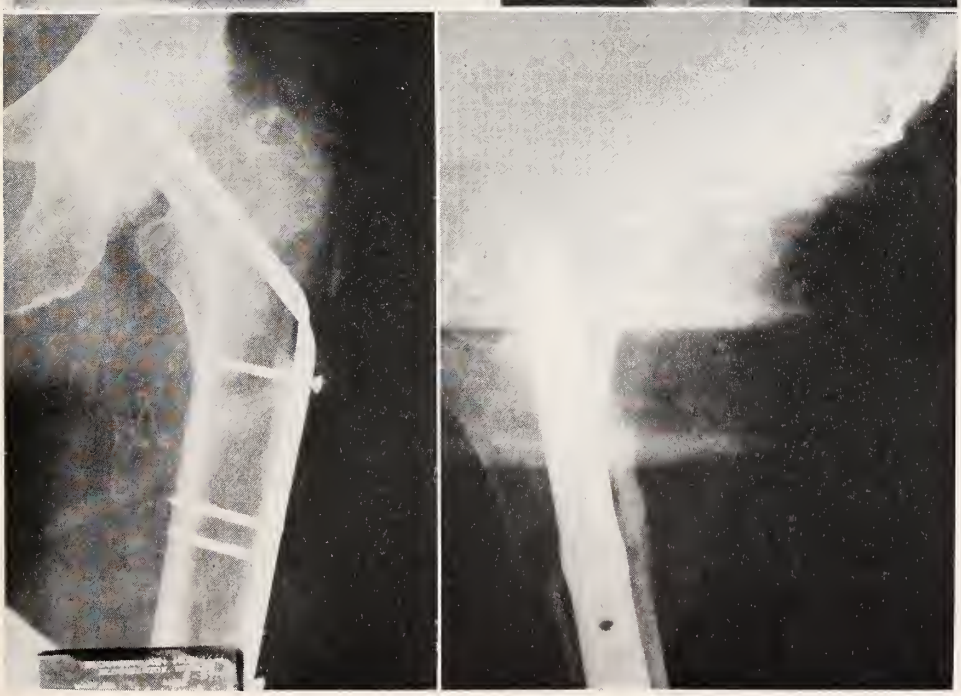
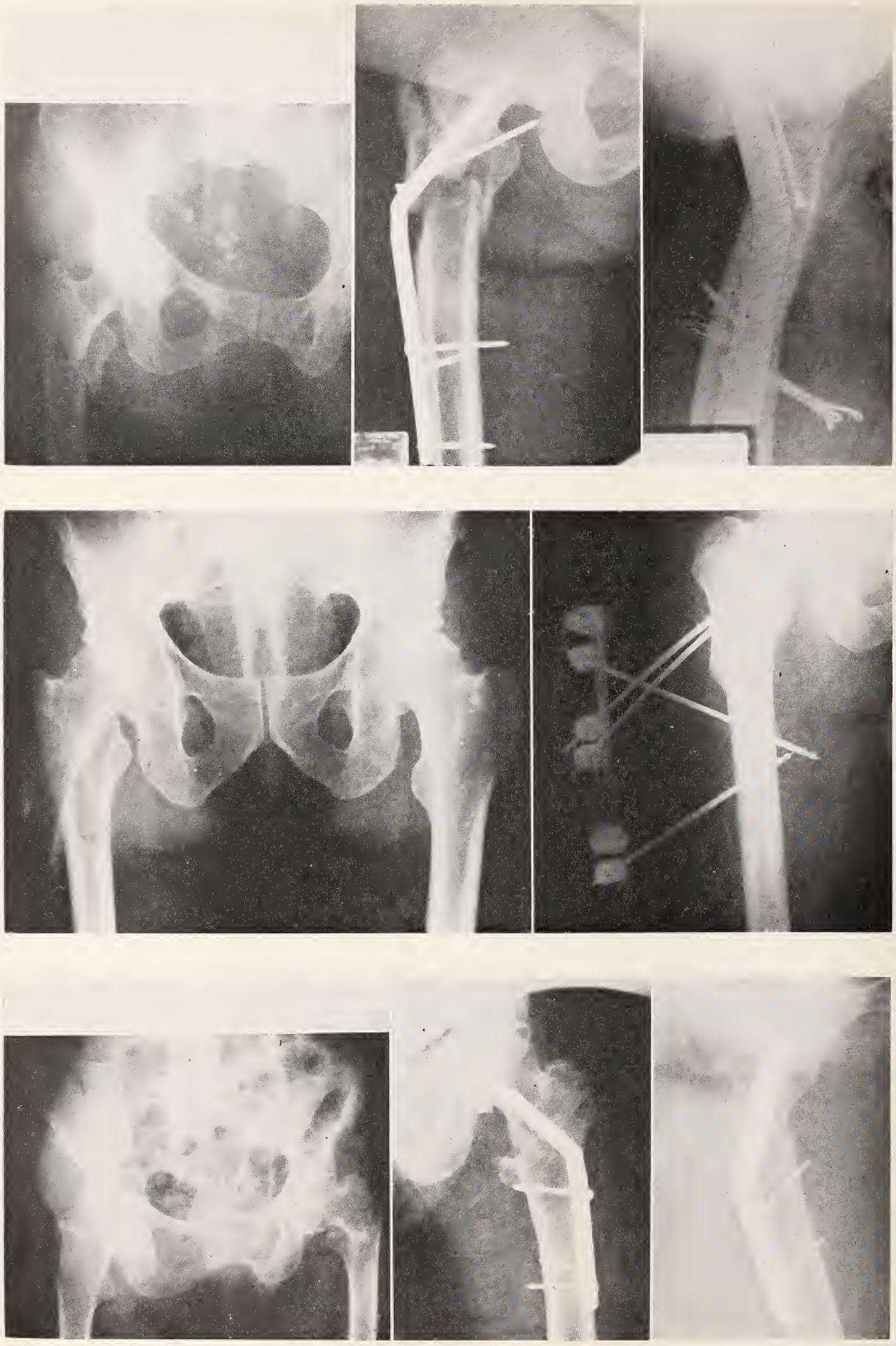


Figure 2b. Case III, Male, age 80, comminuted trochanteric fracture before fixation, AP view. Upper right, lateral view of fracture. Lower left, AP view after fixation with Neufeld plate; and lower right, lateral view after fixation.



to tax the diagnostic and therapeutic ability of any internist or general practitioner.

Now that we have looked at the medical problem let us take a look at the surgical problem with a view to seeing what the medical man who is handling these other complications, and who is probably the patient's family physician, should properly expect from his surgical colleague in the manner of caring for his patients.

In order to facilitate the surgical discussion we will begin at the top and work downward, so we start with a high cervical fracture—one

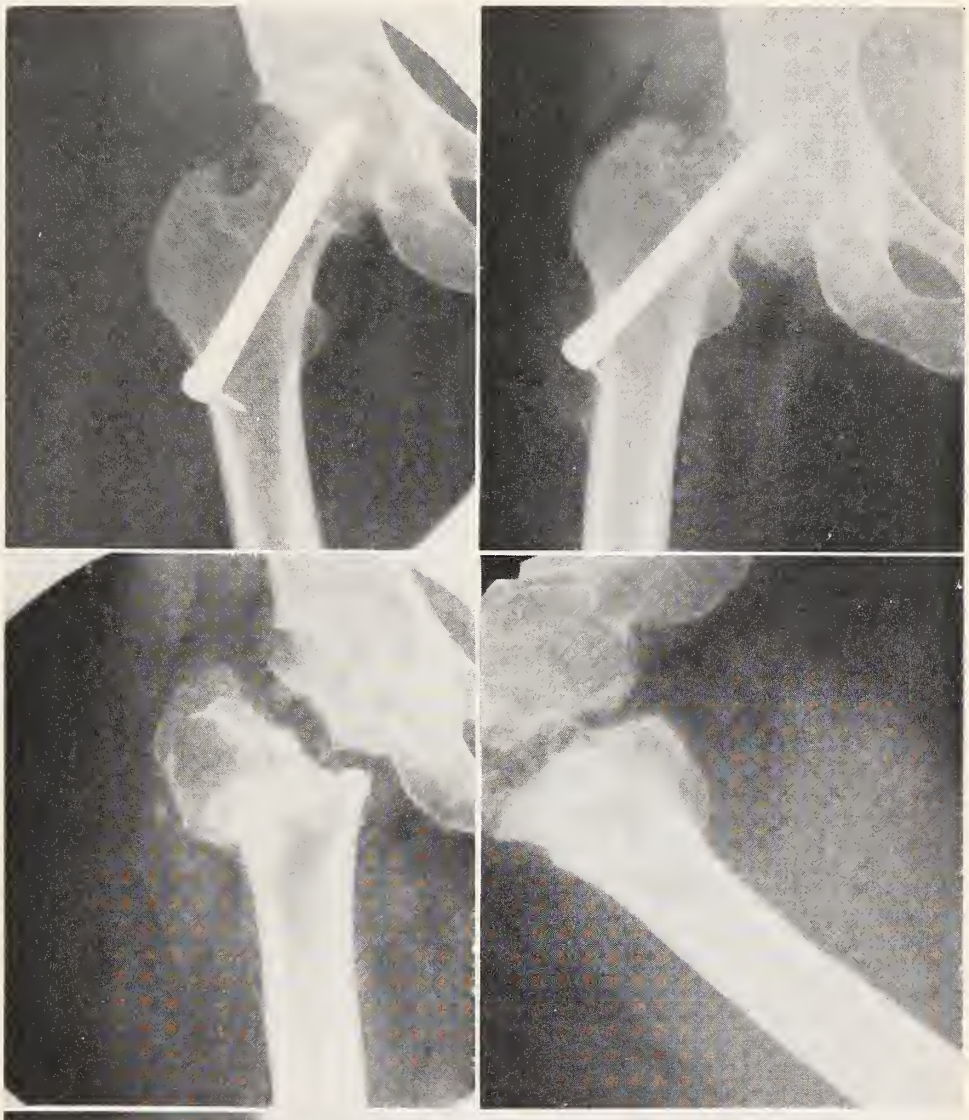


Figure 3a. Case IV: female, age 51, comminuted trochanteric fracture. AP view before fixation. Center, AP view after repair with nail and screws; and right, lateral view after repair.

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Figure 3b. Case V: male, age 75, comminuted per- and sub-trochanteric fracture, AP view before fixation. Right, AP view after fixation with Roger-Anderson pinning.

←

Figure 4. Case VI: female, age 83, per- and sub-trochanteric fracture, AP view before repair. Center, AP view after fixation with Moore-Blount plate. Right, lateral view after fixation.

←

Figure 5. Case VII: female, age 62, fracture of neck with aseptic necrosis after nailing. Right, six weeks later. Center left and center right, 10 months after first plate. Lower left, after osteotomy and 18 months after first plate was taken.

of the highest—running through the head, or with a comminution of the head of the femur itself with small fragments. This is a fracture which may be considered as a possible site for non-union or unsatisfactory union, and therefore one in which we might use an early or primary prosthesis rather than wait for the possibility of healing. It is the writer's opinion that there are proportionately not many fractures warranting this type of treatment, but that such do occur and in those the Collison, Roger-Anderson or Eicher prosthesis may be considered as primary treatment, depending on the fracture character and the surgeon's preference. In these cases this author would prefer to use the Collison-McKeever type, made of stainless steel, because of its mechanical features and the adjustability for neck length. One disadvantage of the plastic types is that they have been prone to break and "creak". When a fracture does occur in a plastic prosthesis the break is not discernible by x-ray.

The fractures just a little lower, which do not involve a complete breaking up of the head, and which yield a satisfactory bearing surface of the top of the femur are represented by those which are lower than the head or high cervical region. These can be treated by any one of the various types of hip nails, one of the simplest being the Smith-Peterson nail, cannulated or plain. Other types of hip nails such as the Neufeld or Moore-Blount will also serve for these higher fractures. This writer prefers the use of the Smith-Peterson nail, cannulated, in such cases and figure 1 shows a high cervical fracture so treated by a well-placed Smith-Peterson nail. Careful and precise placement of the pin in both anterior-posterior and lateral planes is essential. These fractures can also be handled by multiple pinning and numerous other



Figure 6. Case VIII: female, age 62, fracture of neck, with aseptic necrosis, after nailing, AP view. Upper right, lateral view, same date. Lower left, AP view, three months later; and right, Eicher prosthesis in place, one year later.

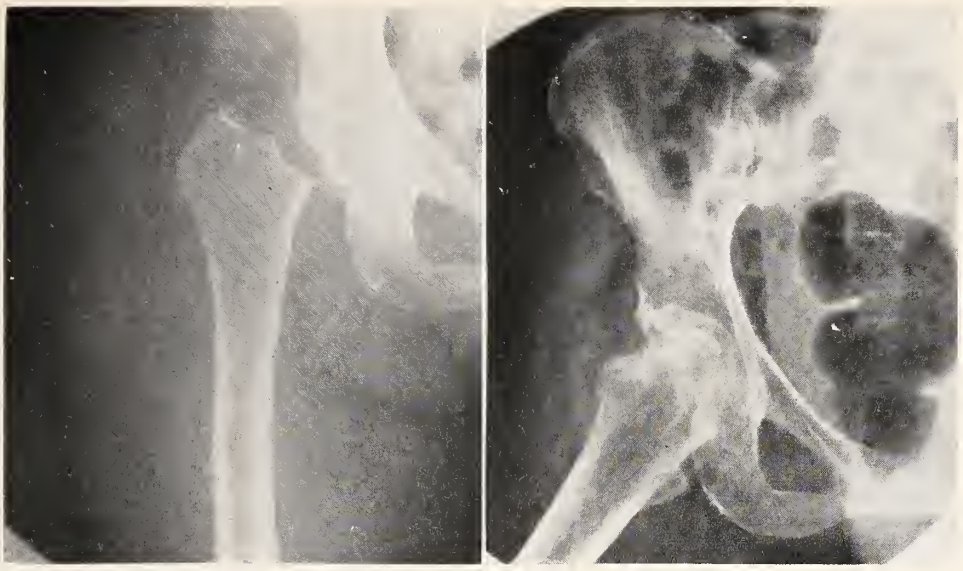


Figure 7. Case IX: female, age 67, bedfast, neglected fracture, AP view. Right, after treatment by Colonna reconstruction.

procedures. The lower cervical fractures or fractures in the mid-section or even slightly lower in the neck can be treated in a similar manner. The Roger-Anderson pinning by multiple external-internal pins is used by some in these cases with the feeling that, in their opinion, it yields greater stability—less chance of slippage of fragments. Numerous other mechanical devices are available according to the preference and past experience of the surgeon.

Fractures involving the trochanteric region or just medial thereto, as well as those just below the trochanters, can be handled quite adequately by the use of the Moore-Blount, or Neufeld plates, or by Jewett or Smith-Peterson nails with the plate additional thereto, and with Roger-Anderson pinning. Those which are below the trochanters, in the opinion of this writer, can best be handled by the Neufeld or Moore-Blount plates, Jewett nail, Johnson nail, or Roger-Anderson pinning.

The Moore-Blount blade plate with the very long blade, extending down the shaft, makes a convenient method for treating fractures which are even lower or in which there is some comminution, as this blade is made long enough in some of these plates to serve to hold these fragments. Some operators like the Roger-Anderson apparatus here, feeling that it gives additional mobility to the joints and leaves no foreign material to be removed after completion of the healing process. Figures 2a and 2b, 3a and 3b, and 4, show such fractures treated by apparatus placed in the manner described above.

In cases where there is non-union of a cervical fracture, or in which there occurs absorption of the neck or aseptic necrosis of the head, satisfactory treatment may be had by means of an osteotomy, as shown in the case of non-union in figure 5, or with a prosthesis as shown in figure 6, where complete absorption of the neck and aseptic necrosis of the head occurred. The Colonna reconstruction is also useful in these cases. An example is shown in figure 7 in an old neglected fracture in a bed-fast patient. One sees only too often fractures which have been neglected, not diagnosed, or treated by application of sandbags, or traction of inadequate character and amount.

The anesthetist's part in this picture must not be underestimated. We know that many of these patients have respiratory infections at the time of injury or immediately subsequent thereto. We have recounted above the many medical factors that make these patients a particularly undesirable group of patients from the standpoint of operative risk. It has been found in our experience that if not too much premedication is used and if the blood pressure is watched during the operative procedure by the anesthetist, these patients tolerate spinal anesthesia very well. It is our feeling that it is to be recommended highly for them. We usually use Pontocaine with some dextrose solution and attempt to limit the extent of the anesthesia in that manner. The Pontocaine takes effect more slowly and hence the adjustment on the part of the patient to any change in blood pressure is more gradual and can be better tolerated, than in the

case of more rapid changes which occur with other more rapidly acting anesthetic agents.

CONCLUSION

To state again what was said in the beginning of this article, here is a prime field for collaboration between the general practitioner or internist and the surgeon. Each one must realize the value and importance of the efforts of the other and the wide range of possibilities available to each in handling these usually complicated situations.

The suggestions made as to the procedures to be used by no means imply a criticism of other techniques or apparatus. It is well known that methods used by one surgeon are frequently not as successful in the hands of another who may not have developed the same techniques or utilized the method as much. It is apparent that we have considered practically all of the mechanical situations involved in the treatment of these fractures and that the family doctor can expect his surgical colleague to have available a method or methods for the treatment of each. In every case close collaboration between the surgeon and internist is essential if we are to better our percentage of survivals and the quality of our end results in these cases of fractured hips in this older age group with its multitudinous problems.

DIET FADS THREAT TO DENTAL AND GENERAL HEALTH

Excesses in diet fads, whether it be over-reliance on vitamins or the so-called natural foods, are a threat to both dental health and general health, it was reported recently in *The Journal of the American Dental Association.*

Four research scientists were sharply critical of "the false teachings of the food faddists" and urged moderation in nutrition.

"The over-emphasis placed on vitamins" was the target of Seymour J. Kreshover, D.D.S., M.D. and Ph.D., professor of oral pathology and director of dental research at the School of Dentistry, Medical College of Virginia, Richmond.

"The widespread practice of massive vitamin supplementation by the American public is the subject of increasing concern," Dr. Kreshover said. "In addition to creating a neglect and carelessness in the selection of other essential foods and a consequent danger of amino acid or mineral deficiencies, such over-medication may also initiate toxicity (harmful effects)."

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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ONE STATE PETITION NEEDED

THIRTY-ONE STATES have now adopted resolutions petitioning Congress to call a constitutional convention for the purpose of placing a limit on the taxing powers of the Federal government.

The affirmative action of only one more state is needed to actuate this method of constitutional amendment. Proposal of amendments through the state legislatures rather than by the Congress has been used only a few times. The resolution regarding Federal income taxes has been going the rounds for several years. The states have varied slightly on details, but all those who have passed the resolution have agreed on the basic principle of limiting the Federal tax power to a sensible figure of around 25 per cent except in time of national emergency when there would be no limit or a limit higher than 25 per cent.

The need for a limitation has been realized for many years. State legislatures have acted on the proposal, a few each year, until now with the recent assent of South Carolina the required two-thirds is almost attained.

The culmination of this unusual process of constitutional change comes at an appropriate time—a time when the forces of socialization are more and more apparent, and when the socialization of medicine is still a possibility. Limitation of the Federal taxing power is an antidote for socialization. Socialization is an expensive process. We will never have it, or at least we will have no more than we already have, if we can limit Federal spending to the necessities.

NEEDED NATIONAL LEGISLATION

FAVORABLE NEWS LETTERS have come from Washington mentioning that the Jenkins-Keogh Bill, authorizing self-employed professional men to make tax-free endowment building deductions would likely pass during this session. Lately, however, no word has come, and we are fearful the effort may be relaxing and we may again be left waiting.

Our members will remember that this bill places self-employed professional men on a slightly more favorable basis as compared to leaders in industry. Employers of executive and administrative personnel for many years have been allowed to set aside as "expense before taxes," sums of money to establish endowments for their executives—and these items are not all small. Recently, a well-known chairman of the board of a large industry announced his retirement, on a "salary" of $75,000 a year. He will pay taxes as he receives his allotments, but his company, in establishing the sponsoring fund, has been tax free.

We have suggested for more than ten years that medical men, attorneys, dentists, self-employed professional men, be granted a similar benefit—nothing exceptional or unusual—but a small degree of equality with our friends in the business world. At first, we suggest that the government establish a new endowment bond, similar to the tax-anticipation bond of the later war years. One eligible could invest up to 15 or 20 per cent of income each year; the interest was suggested to be small until the conversion into endowment.

The advantages would be a new outlet for Government bonds, and the Government would have the use of all the invested money. A bond sales program now in evidence might be eased. The investor would be placed on a plane somewhat more equal to his contemporaries.

Jenkins-Keogh introduced a bill accomplishing a somewhat similar purpose, for which we would settle, but we fear more letters are needed by our Congressmen in Washington. We hope no feet are dragging.

AUTOMOTIVE CRASH INJURY RESEARCH

ENGINEERING and medical research to improve the safety of automobiles is expanding rapidly, and is attracting the financial support of government and industry.

The Cornell Automotive Crash Injury Research, with which a similar project of the Indiana State Police has been associated since 1952, has just issued an annual report for the 12 months ending March 31, 1956.

Research into the causes of fatal injury in automobile accidents originated in Marion County in 1949, later was enlarged to include the entire state. It became affiliated with Cornell University Medical College because their Department of Public Health and Preventive Medicine had had extensive experience in a similar investigation in regard to airplane construction.

During the past year the states of Indiana, Maryland, North Carolina, Virginia, Connecticut, Arizona, Texas, Vermont, California and Minnesota have participated. Police officials and physicians have cooperated in reporting the details of accidents in order that the factors in lethal accidents could be studied in an epidemiological fashion.

The project is sponsored by the Armed Forces Epidemiological Board and receives funds from the U. S. Army, the U. S. Public Health Service, the Ford Motor Company and the Chrysler Corporation.

One of the findings which appeared early in the research and which has been verified many times is that the mortality rate is about doubled in the case of a person who is propelled from

the car by an accident. This finding has resulted in improved door latches and in a growing popular demand for seat belts. To the expanded interstate program has been added an information collection system for large fleets of passenger cars, so that sufficient data may be collected to ascertain what effect these safety factors will have.

Mortality rates for two-door and four-door sedans demonstrate that the four-door model is a little more productive of fatalities. The difference is almost entirely accounted for by the fact that there are more doors to pop open and more passengers to be ejected.

Studies of the relation of injury to speed indicate that at least part of the increase in injuries which accompanies increase in speed is due to the increased likelihood of door failure and ejection of passengers at the higher speeds.

The fact that more passengers are seriously injured in rollover accidents is accounted for by the observation that rollover accidents result in more doors popping open and therefore in more people being expelled from the car. Occupants who stay in the car in a rollover accident suffer no more serious injuries than those who stay in the car in a non-rollover accident.

These and many other questions, such as the effect of windshield glass on injuries, are being studied. An injury tabulation to indicate the frequency and severity of injuries to various parts and systems of the body is being prepared. A special study is being made on head injuries as produced by the automobile.

One of the most interesting reports in the future will be the data on the effect of safety latch doors and seat belts. All the figures to date would indicate that these two items should prove to be of major life-saving importance. Their actual test in automobile crashes will no doubt indicate this and will further their popularity.

FOUNDATION TO CONTINUE PRACTICE GRANTS IN 1956

Assistance in the establishment of 10 medical practice units in eight states has been announced by the Sears-Roebuck Foundation.

The loans, made under the foundation's 1955 plan of assistance, range from $3,000 to $25,000. The foundation, which introduced its plan last September, grants long-term, unsecured loans to physicians to enable them to complete the financing of their practices.

The foundation administers the plan, while the screening and selection of applicants is done by a 17-man advisory board of leading physicians named by the trustees of the American Medical Association.

In announcing the 10 grants, the foundation also said it has allotted $125,000 for continuing the plan of assistance in 1956. This amount, plus the $24,000 remaining from the 1955 budget, will make a minimum of $149,000 available for the program during the coming year.

Loans last year went to 18 doctors setting up 10 practice units in eight states. The units fall into two categories: those which bring medical care and facilities to communities where none exist, and those which retain existing care and facilities in areas about to lose them.

Eight of the units are being established in small towns in northern Georgia, central Oklahoma, northeast Oklahoma, southwest Colorado, northern Texas, Southwest Michigan, southeast New York, and Connecticut. The others are in suburbs of Tulsa, Okla., and Seattle, Wash.

ACHROMYCIN*

Tetracycline *Lederle*

in the treatment of

infections in surgery

The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout[1] have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot and his associates[2] used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

As a prophylactic and as a therapeutic, ACHROMYCIN has shown its great worth to surgeons, as well as to internists, obstetricians, and physicians in every branch of medicine. This modern antibiotic offers rapid diffusion and penetration, quick development of effective blood levels, prompt control over a wide range of organisms, minimal side effects. There are 21 dosage forms to suit every need, every patient, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Broad-range antibiotic action to fight infection; important vitamins to help speed normal recovery. In *dry-filled*, *sealed* capsules for rapid and complete absorption, elimination of aftertaste.



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[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

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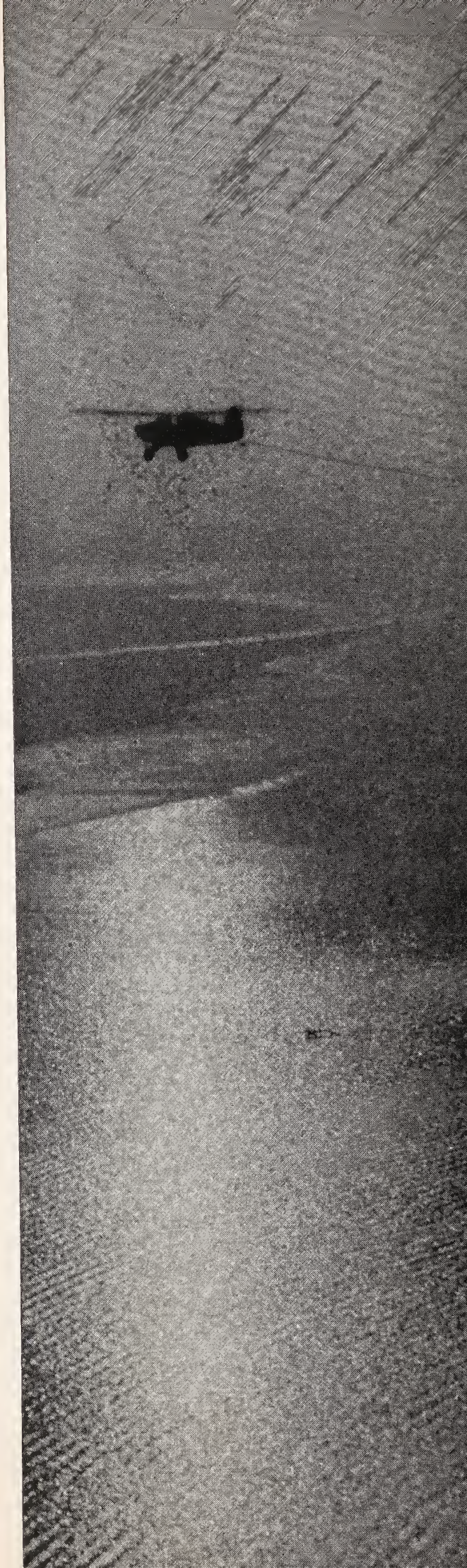
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ACHROMYCIN ACHROMYCIN [redacted]

The President's Page

A SIMPLE SYLLOGISM accurately sets out a basic obligation of every doctor.

Every good citizen has a constant interest in government. Every physician is a good citizen. Hence, every physician has a constant interest in government. It is as simple and direct as that. Thousands of words cannot more accurately express a fundamental duty.

The only possible error is in the corollary statement. Is every physician a good citizen? If it is not entirely true, why? Is it complacency? Or simply mental sloth? It would be unthinkable to suggest this obvious alternate.

The ancient traditions have always been based on deep interest in the commonweal. The success, the growth of our country has always depended upon a continuing interest in every phase of our government.

It follows then that every physician owes to his country and to his profession, constant effort to guard against every form of attack on the basic welfares. It, also, means a constant effort to protect improvements, which by logical and practical means, increased the value of our efforts in our special field; and constant, unrelenting opposition to every proposal, which conceivably lessens and deteriorates our influence and our progress. This rather labored argument then calls for participation in politics by every medical man. The continued existence of the standards of effort, of constant widening of our horizons, and maintenance of our authority in health matters demand individual participation in every form of social change, not as partisans, but as independents supporting those whose views we consider sound. That participation should be in every health movement, keeping within our evident bounds and having leeway for individual beliefs in foreign and domestic issues not directly affecting the health welfare.

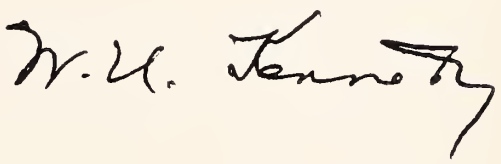
Candidacy for office is unimportant. A close scrutiny of candidates is our best approach. We will be better off by avoiding party labels, permitting throwing our considerable influence to individuals rather than party. Our interest lies in the Congress, but on occasion may go down even to local matters. Membership on school boards, sanitary commissions and welfare boards come clearly within our province. We ought to be consultants, rather than leaders, thus avoiding charges of personal or professional profit.

I have observed over many years that a secretaryship is more important than a chairmanship. Let the titles be used as plums for our lay supporters. There will be times when a positive declaration by a local medical society will be decisive. But above all avoid being labeled as "party" partisans. Let the standard of effort be free from anything but the public good. By so doing,

we shall continue to be a most powerful influence in shaping public opinion. And until the AMA sets up a competent political division, we will do best by running our affairs on a local basis. After all, the grass-roots area continues to be the most potent factor in decisions at every level.

Our recent dinner to all of our Indiana Congressmen, devoted solely to establishing better personal relations, was highly successful and ought to be continued each year. We are no longer suspected of being single-minded and fanatical.

Reported expressions of increasing good will toward us were heart warming; and the value of personal approaches even to government officials was shown by the friendly reception and the almost instant approval of our new VA contract. We now have a contract in which every item is equal to the highest in every surrounding state. Our Veterans Committee did an outstanding job in setting up the manifold items and deserves our warmest thanks. The job was so well done that we settled the matter with top authority in 30 minutes, surely a record in governmental negotiations.



The Woman's Auxiliary

REPORTS TO I.S.M.A.

In reviewing the accomplishments of the past year, my outstanding impression is of a friendly, dedicated group of women happy to supply leadership in their communities and state. Wherever I went, North, South, East or West, visiting county, district, regional and state meetings, I was received with cordiality, and eagerness to report what each had done. I was always glad to pass on all the many helps National had sent to me as President.

Indiana's 2,526 members feel a personal responsibility to support the American Medical Education Foundation and have subscribed $7,558.44 to date. The money has been raised by the following means: approximately 30%, or $2,321.34, from Memorial cards; the rest from assessments, programs, entertainments, teas, luncheons, sales of handmade articles, rummage, white elephant, and hat sales. At the Indiana State Medical Association convention in October the Woman's Auxiliary dedicated the main luncheon to the American Medical Education Foundation with the Dean of Indiana University School of Medicine, Dr. John D. Van Nuys, as speaker. He brought before us vividly the situation which our own medical school faces. The film, "Danger at the Source" was shown and has been shown widely over the state since.

Our Auxiliary has been pleased with the appearance and content of Today's Health magazine and members have been proud to promote its sales in Operations Christmas, and Doctors, and Dentists. As of April we have 2,110 subscriptions. It is our hope that all officers will use the Bulletin as a reference and textbook on Auxiliary projects. We receive 119 subscriptions.

Last year Indiana distributed a Program book to the county presidents outlining the various projects and activities of Auxiliary work. This was continued this year with workshop training added. Early in the year four regional meetings were held in state parks, where committee chairmen and state officers met with county officers and committee chairmen in their respective vice-presidential regions, and talked over Auxiliary work and goals. The group meetings were well attended and brought a unity to the program and a feeling of responsibility for its success. These meetings were particularly valuable to the state officers, in being able to meet personally so many local officers and learn about their problems and opportunities. We were friends working together from then on.

In the Fall Assembly, the committee chairmen were allotted time for conferences, with a briefing on Public Policy and Legislation by Dr. J. William Wright, Sr., co-chairman of that Indiana State Medical Association committee.

We had hard-working and efficient program and public relations chairmen, but we feel there is an overlapping of subject matter and that there should be a re-evaluation of the purposes of these committees. It would be advantageous to cut down on duplication of reporting, since a multiplicity of reports makes for slackness in all reporting. Indiana is studying the content of these committees to eliminate so much duplication.

Indiana has been putting increased emphasis on Rural and School Health and Safety Education. The Medical Association and Auxiliary committees have met to plan county meetings. Three Health Day conferences and one on Safety were held. Plans are under way to urge every county to observe a Health Day next year. As we are concerned with the health of the community, in every Auxiliary we have had generous response to calls for community health drives. As individuals, doctors' wives have led in Cancer, Heart, Polio, T.,B. Red Cross and other cam-

paigns. All over the state doctors' wives who have had nurse's training have assisted with polio vaccinations, pre-school roundups, and Civil Defense programs. They, as individuals and as Auxiliary groups, have led in promoting hospital auxiliary projects, from gathering $500 for groceries for a hospital pantry, furnishing rooms for nurses' recreation, establishing a doctors' room, obtaining needed funds, running a gift shop or cart for patients, to helping in the sewing room or pediatrics wards,—in fact doing whatever is needed. One group learned to transcribe Braille for the library, and spent regular time making added reading available to the blind.

Practically all members with children are active in the PTA, Boy and Girl Scouts, 4-H, Y.M. and Y.W.C.A. work, and many reports come in regarding Sunday school and church work and civic club memberships.

Five state officers attended the Legislative Conference in Chicago and material was sent to all counties.

Auxiliary information, publicity and personal news is brilliantly handled by the editor of the Hoosier Doctor's Wife, published four times a year. We also have a page, "The Auxiliary Reports" each month in THE JOURNAL of the Indiana State Medical Association. Many counties have their own publications or a page in the county medical bulletin.

As of April 1956 we have 2,526 members, of which 16 are associate members and 12 members-at-large. Indiana is divided into 13 districts with 64 organized county Auxiliaries.

We have accomplished the following in nurse recruitment:

Loans since inception	$3,590.00
Gifts in scholarships (current)	4,764.23
Gifts in scholarships (since inception)	23,515.24
Gift to graduate nurse	350.00

58 nurses in training
42 Future Nurses clubs organized
$100 is allowed in the state budget for a nurses scholarship to a 4-H girl

A nurse recruitment film was shown to all schools in one county; Auxiliary members drove more than 2,000 miles taking a nurses' staff to talk to high school girls in another county; still another county sent three student nurses to the State Nurses convention. Many county Auxiliaries arranged Hospital Education or Job Opportunity in Medicine programs. The Indiana State Technicians Association would like to work with the Auxiliary along these lines.

There has been increased interest in mental health and our mental hospitals this past year. We had almost 100% participation in the Christmas gifts to mental hospital patients project, as well as some personal service. Indiana has an Auxiliary member on the State Mental Health Board and one on the National Board. Auxiliaries close to mental hospitals have made service to the hospitals a part of their programs.

We have had an intensive enlightenment campaign through the Blue Cross-Blue Shield medical insurance plan. Conferences were held on state, district and county levels to inform the membership.

The Woman's Auxiliary to the Indiana State Medical Association has worked diligently, the reward is in the doing. We are grateful for the opportunities offered.

Respectfully submitted,

Helen W. Mather

Mrs. J. Winford Mather, President 1955-56

What Americans Think of the Medical Profession: Report of a Survey

Views about medical economics are reported in the following instalment of the extensive survey made for A.M.A. by an independent opinion and market research firm.

The July Instalment will deal with views on organized medicine.

SUMMARY II—PART II

IS THE PUBLIC as critical of the economic side of medicine as some people think? To gauge public opinion on medical costs the public survey included a number of economic questions. Here is what the survey showed.

Individual doctors' charges receive only moderate criticism by the public. In summary 1 earlier questions phrased about "my doctor" and "most doctors" brought out the fact that only 16% of the public believe their own doctors charge too much while 43% say most doctors' fees are too high. It was also shown that only 13% think their own doctor's charges have gone up faster than other living costs, while 35% say this is true of most doctors' fees. Ninety per cent deny their own doctors plan to get rich quick and 70% deny most doctors do. Doctors themselves express the opinion that their charges are that aspect of medicine of which the public is most critical.

People think their own doctors do not make too much money and only about one-third of the public think most doctors do. Two-thirds of the public deny that "compared with his patients" their own doctors make too much money. When asked, "What about him gives you the idea that he makes too much money?", only 13% mention any reasons. Four per cent say, "because he lives well, has luxuries"; another 4% mention "his charges"; 2% say they draw this conclusion because of the number of patients he has, and 1% say "because he has money". About one third of the public (38%) say they think that "most doctors" make too much money, but 44% deny the charge. Eighteen per cent state no opinion. Only 7% of the doctors themselves reply that physicians' incomes, compared with those of their patients, are too high.

Only small numbers of people believe doctors charge higher fees to people who carry medical insurance. Again, only 13% of the public say their own doctors charge higher fees to people with medical insurance and less than a third (31%) say most doctors do. A small percentage of doctors themselves (18%) agree that physicians hike fees for people with insurance.

Groups that are most critical of doctors' fees and incomes include lower-income people, southerners, non-white, people without family doctors, and those with only grade-school education. Here is how these groups compare with the general sicians hike fees for people with insurance.

Think That Most Doctors	Lower Income People	People in the South	Non-Whites	No High School	Have No Doctor	Total Public
Charge too much	48%	49%	47%	49%	49%	43%
Have raised fees too fast	42	40	43	41	38	35
Charge more to policy holders	33	37	33	34	37	31
Make too much money	44	44	37	42	46	38
Plan to get rich quick	35	38	35	38	36	30

IMPORTANT RESEARCH CONTRIBUTION

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PROTEOGENIC EFFECTIVENESS • The newest Searle Research development, Nilevar, exerts a potent force in protein anabolism. Yet it is without appreciable androgenic effect (approximately one-sixteenth of that exerted by the androgens).

Investigations with Nilevar show that nitrogen, potassium and phosphorus are retained in ratios indicating protein anabolism. Nilevar is thus the first steroid which is primarily anabolic and which provides a practical means of meeting the numerous demands for protein synthesis.

NILEVAR IS ORALLY EFFECTIVE • Clinical response to Nilevar is characterized not only by protein anabolism but also by an increase in appetite and an improved sense of well-being.

SAFETY AND PRECAUTIONS • Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently.

DOSAGE • The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the daily dose is 1 to 1.5 mg. per kilogram of body weight. Individual dosages depend on need and response to therapy. Nilevar is available in 10 mg. tablets. G. D. Searle & Co., Research in the Service of Medicine.

INDICATIONS:

Nilevar is indicated in the vast area of surgical, traumatic and disease states in which protein anabolism is desirable for hastening recovery. The specific indications are:

1. **Preparation for elective surgery.**
2. **Recovery from surgery.**
3. **Recovery from illness: pneumonia, poliomyelitis and the like.**
4. **Recovery from severe trauma or burns.**
5. **Nutritional care in wasting diseases such as carcinomatosis and tuberculosis.**
6. **Domiciliary care of decubitus ulcers.**
7. **Care of premature infants.**



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SEARLE

"Compared with his patients My doctor DOESN'T make too much money" say 2 out of 3



Only 1 out of 8 thinks he DOES

In connection with a query about doctors' charges, the public was asked, "which, if any, do you think are most likely to charge more than they should—general doctors, surgeons, or other specialists?" Other specialists are mentioned most often (54%). Surgeons are listed by 29%, and general doctors by 3%. Six per cent say "none or equal". Most critical (60%) of the charges of other specialists are people in the Central States (General public, 54%).

The public thinks of doctors as being much better businessmen than doctors do. Doctors are convinced that they are poor businessmen, but the public takes an almost diametrically opposite view, especially with their own family doctors. Only 13% of the doctors themselves say most doctors are good businessmen, yet two-thirds (67%) of the public say their own doctors are, and almost half (48%) say most doctors are. The people deny that most doctors are not good businessmen for these reasons: they live well and are successful (10%); they are intelligent and capable (7%); they make money (5%); their billing and business activities (5%).

Physicians say medical men are not good businessmen because they: are too busy (21%); are easy marks, avoid other business (17%); are not trained in business (16%); keep poor records and follow poor billing practices (12%); are interested only in medicine (11%); and don't think about money (4%).



"DOCTOR BILLS HAVEN'T GONE UP as fast as drugs and hospitals"

THIS IS THE PREVAILING OPINION

41% say HOSPITAL charges
32% say DRUG costs
9% say DOCTOR bills

HAVE RISEN FASTEST

The two groups with the highest agreement (23%) that most doctors are not good businessmen are people of college background and upper income people.

The public is by no means so critical of doctor bills as it is of other costs of medical care. Of all economic aspects of medicine, physicians' charges are least criticized. Doctors' fees are thought to have risen the least since World War II in comparison with hospital and drug bills. In answer to the question, "Which part of the cost of medical care would you say has gone up in price fastest since World War II—doctor bills, hospital bills, or drug bills?", the following responses were tallied:

	Public	Doctors
Hospital bills	41%	71%
Drug bills	32	24
Doctor bills	9	1
No opinion	18	4

Almost five times as many people say hospital bills have risen the fastest as say doctors' bills have. Almost four times as many mention drug bills as having increased with the greatest speed. The fact is that hospital bills have been increasing at the sharpest rate of the three.

In each instance, people naming a specific type of bill as having risen fastest generally claim the increase has been too great. Yet doctors' fees are least criticized on this count. Only 7% of the 9% who say doctors' bills have risen with the greatest speed say the fees are higher than they should be. But 26% of the 41% who list hospital bills first say hospital charges are excessive and 23% of the 32% who mention drug bills first claim these bills are higher than necessary.

"Do you think that hospital (drug, doctor) bills are higher than they need be or not?"

	Public			Doctors	
	Hospital	Drug	Doctor	Hospital	Drug
Yes, higher	26%	23%	7%	25%	14%
No, not	10	5	1	35	8
Qualified or no opinion	5	4	1	11	2
Total %	41%	32%	9%	71%	24%

Only 1% of the medical profession itself thinks that doctor bills have risen fastest; 71% of the doctors say hospital bills and 24% of the doctors say drug bills have climbed with the

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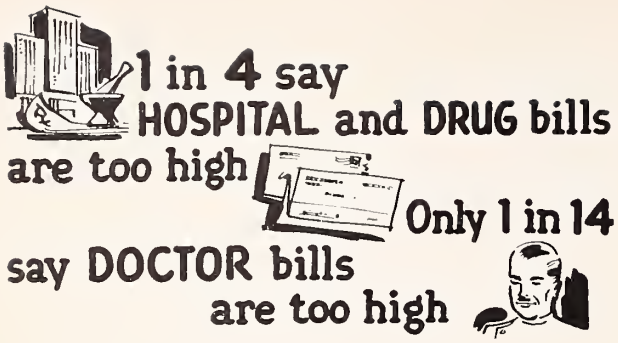
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1. Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia 25:67 (Feb.) 1956. 3. Mitchell, E.H.: J.A.M.A. In press.

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greatest speed. Doctors, however, are more inclined to defend than criticize increases in hospital charges. Of the 71% naming hospital charges, only about one in three (25%) think these charges are higher than they should be, and 35% say they are not. A greater percentage (14%) of doctors who say drug bills have climbed fastest (24%) say charges for these products are higher than necessary.

Both public and doctors were also given the opportunity to list their opinions as to the reasons why costs have risen so fast. The chief reasons given for the increases are for the most part not critical and practically no one blames the doctors for increases in hospital or drug bills.

	Public			Doctors	
Reasons for increases in charges	Hospital Bills	Drug Bills	Doctor Bills	Hospital Bills	Drug Bills
Labor costs	16%	4%	1%	47%	4%
Material, equipment costs	13	3	1	33	3
General inflation	9	5	3	12	2
Profiteering	3	6	3	1	3
New Drugs, research	1	8	*	1	11
Advertising expense	—	*	—	—	4

(And miscellaneous other reasons) * Less than ½%

Labor, material and equipment costs, and general inflation are blamed mainly for increased medical costs by both doctors and the public. Only small percentages of the public cite profiteering as the reasons for higher costs. This indicates that most people, though aware that medical costs have risen since World War II, are not incensed about increases and view these increases as they do increases in other living costs.

Even in those sub-population groups who might be expected to be more critical of doctors' fees, for example, little variation between opinions of the general public is seen:

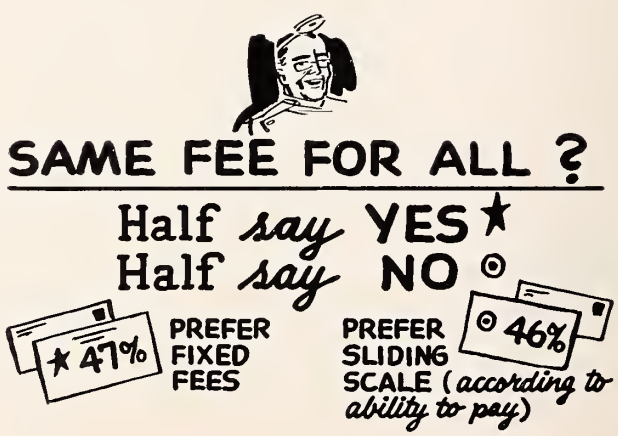
Think that doctor bills—	Lower Income People	People in the South	Non-Whites	No High School	No MD	Total Public
Have gone up fastest	13%	10%	11%	9%	12%	9%
Are higher than necessary	11	8	6	6	9	7

People are evenly divided on the question of fixed fee scales, while doctors favor sliding scales by about 2 to 1. For years doctors have charged in large measure according to the patient's ability to pay. In the past few years medical insurance has tended to bring about pressures for more standardization of medical costs. Yet, according to the survey, the move to establish fixed fees is not yet in demand by a majority of the public. The traditional sliding scale has practically as much support. When the public was asked, "Do you think that doctors should charge the same fees to all their paying patients or that they should charge more to patients who have more money?", they reply:

	Public
Same to all	47%
More to some	46
Qualified answers	3
No opinion	4

A majority of people have the impression, however, that their own physician does employ a fixed fee scale. More than half (55%) say that except for charity cases, he charges all patients the same fees while about one in four (23%) say he does not charge the same. Twenty-two per cent have no opinion on this question.

The medical profession apparently still is inclined toward the philosophy of charging ac-





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cording to ability to pay. Two out of three doctors say they think doctors should charge more to some patients, while one out of three favor charging the same fee to all. Many physicians object to the wording of the question, "Do you think the doctors should charge the same fees to all their paying patients or that they should charge more to patients who have more money?", saying it should read instead, ". . . charge less to patients who have less money".

	Doctors
Same to all	32%
More to some	62
Qualified answers	4
No opinion	2

The public wants cost estimates for treatment of major illnesses. Three persons in four think their doctors should give cost estimates for the treatment of major illnesses. Most doctors say they do this, but only half the public confirm this claim. Only one person in eight (12%) thinks the cost should not be discussed in advance.

"Do you think he should tell his patients ahead of time what he thinks the cost will be?"

	Public
Yes, he should	76%
No, he shouldn't	12
Qualified answer	8
No opinion	4

Three people in ten (30%) say the doctor does not prepare them in advance for the cost of treatment. Almost half (48%) say he does give them advance estimates, but about a fifth (22%) do not hazard an opinion. Three-fourths (77%) of the doctors say either that they usually tell patients about the expected cost or that they wait until asked to discuss fees.

"Do you usually tell your patients ahead of time about what the cost of treatment for major illnesses probably will be?"

	Doctors
Yes, I do	60%
Yes, if asked	17
No, I don't	18
Qualified answers	4
Don't know	1



"I TELL MY PATIENTS what it will COST"

***say* 6 out of 10 doctors**

Another 1 in 6 tell when asked
Another 1 in 6 don't discuss fees



"MY DOCTOR DOESN'T SPLIT FEES"

***say* 3 out of 4 who express an opinion**

(But 57% of people have no opinion)

The fact that three out of four doctors do discuss costs in advance indicates that the campaign of the American Medical Association to encourage this procedure is meeting with nationwide acceptance.

Despite publicity on the subject, only a minority of the public knows what fee-splitting is. Even though they cannot define it accurately, they disagree with the doctors' feeling that reports have overstated it. When asked what the term "fee-splitting" meant, only 15% give correct definitions, 23% give incomplete definitions, 8% give incorrect definitions. and more than half (54%) admit they don't know what it is. Highest understanding of the term, including those giving possibly correct definitions, is found among the upper income group (63%) and the college-trained group (65%). Least understanding of the term (14%) is revealed by nonwhites.

Only 11% of the public say their own doctors split fees on referrals to other doctors, but 57% give no opinion. Twenty-nine per cent say most doctors split fees on referrals, but again, more than half (51%) do not venture an opinion. Only 5% of the doctors say that most physicians split fees and 91% deny that doctors do. Evidently there is still considerable misunderstanding about the subject.

Considerable publicity has been given to the subject of fee-splitting in the past two years. Of the 38% of the public who give correct or possibly correct definitions, 17% say that it has

not been exaggerated. Four out of five doctors say that it has been greatly exaggerated.

"Do you think that the amount of fee-splitting has been exaggerated to the public or not?"

	Public	Doctors
Yes, it has been	10%	81%
No, it has not been	17	9
Qualified answers	1	3
No opinion	10	7

Apparently, not everyone among either the public or the medical profession, condemns fee-splitting. When asked what should be done about it, only 18% of the doctors and 8% of the public say "Stop it", giving no method. Six per cent of the public and 9% of the doctors reply, "Nothing, it's necessary, all right." Medical society action or expulsion is suggested as a panacea by 15% of the doctors and 3% of the public. The same percentage of people (3%) say "leave it to doctors and their own ethics", and 5% of the doctors agree. The following courses of action also are suggested: legislate against it (Public, 1%; Doctors, 3%); separate fees (Public, 1%; Doctors, 5%); tell the patient (Public, 1%; Doctors, 6%); and establish an equitable fee scale (Public, 1%; Doctors, 9%). Eighteen per cent of the doctors give no suggestion and 11% of the public say they don't know what should be done about it.

As might be expected, the highest ratios of those who say fee-splitting has not been exaggerated to those who say it has been are found among people who do not like most doctors (5 to 1) and those who do not like the A.M.A. (3 to 1).

In the medical profession itself, surgeons least often deny that the extent of fee-splitting has been exaggerated to the public, but they absolve most doctors of engaging in it. General practitioners most often (86%) say that reports have been over-stated.

"Do you think that the amount of fee-splitting has been exaggerated to the public or not?"

	General Practitioners	Internists	Surgeons	Other Specialists
Yes, it has been	86%	74%	64%	80%
No, it hasn't	8	9	14	9
Qualified answers	1	5	10	4
No opinion	5	12	12	7

But only 2% of the surgeons, as compared with 7% of the general practitioners and 3% of other specialists say that "most doctors" split fees.

A somewhat related question with ethical as

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well as economic aspects was asked to get opinions about the practice of getting commissions on drug prescriptions. People were asked, "Does your doctor get a commission from druggists on his prescriptions?", to which only 17% say "yes" and 31% say "no." However, more than half (52%) give no opinion. Yet, when the same question was asked about most doctors, three out of ten (30%) say "yes" and only 22% say "no". Why opinion should be more solidified where most doctors are concerned is not certain, but it evidently bears out the findings of the survey that people are more inclined to accept unfavorable assumptions against doctors in general than they are about their own physicians.

No doctors say it is definitely true that most doctors get commissions from druggists and only 1% say this is probably true. Ninety-five per cent deny that doctors do get commissions on prescriptions.

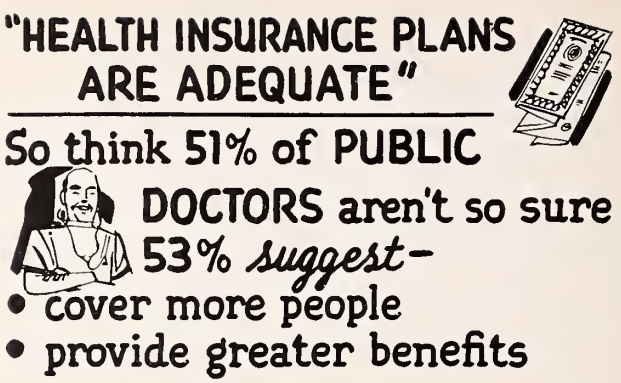
Half of the public is satisfied with present insurance plans, but more doctors say insurance plans are not meeting the need. Another question pertaining to the economic side of medicine was asked to evaluate people's opinions in regard to the adequacy of health insurance plans. Half of the people (51%) show satisfaction with present plans. But not quite half of all the doctors are satisfied that plans are adequate since 53% say they are not filling the need. The chief need that doctors think is not being met is full-population coverage, while the public is less explicit in describing any indequacies they feel exist.

"What more is needed?" (In regard to health insurance)

	Public	Doctors
Wider population coverage	6%	22%
Chronic illness coverage	3	12
Medical doctor, office, house call coverage	2	9
Drug and medicine coverage	1	*
Coverage (other or not specified)	9	11
Payments too low	5	5
Costs too high	5	4
Too many loop holes, cancellations	4	4
Plans are abused	1	1
Miscellaneous mentions	5	13

* Less than ½%.

The highest degree of protest that existing medical and hospital insurance plans are not filling the need comes from those who dislike the A.M.A. (61%). Next highest (36%) comes from those in upper income groups and college-trained people. Doctors in the West show highest dissatisfaction with existing medical and hospital insurance plans. Five-eighths (63%) of them compared with about half of the doctors (49%-52%) in other sections of the country say present day insurance plans are not filling the need.



Doctors expect the public to be more critical of medical costs than they actually are. Throughout that portion of the survey dealing with views on medical bills and medical economics, it is quite clear that physicians themselves anticipate greater criticism of medical fees than the public actually voices. Doctors' charges come in for the least amount of criticism, for only one person in ten registers disapproval. Some people may believe that doctors make too much money, but this may be partially explained by the fact that people lose sight of the long working week of the physician. The average doctor puts in at least one extra eight-hour working day each week which the average person takes as a holiday. Also, the belief that doctors make too much money, even though it is not widespread, may reflect the very human trait of envy of those who are more prosperous, whether prosperity is justified or not. Even increases in hospital and drug bills, which are considered to have risen faster than doctor bills by the public, apparently are accepted by most people as a part of the inflationary economy. The widespread belief that existing health insurance plans are satisfactory reflects a healthy reliance on self-management of income needs where medicine is concerned. The medical profession, which is not yet completely satisfied with today's health insurance plans, can continue to work toward development of the kind of coverages which will eventually eliminate any complaints about the economic side of medicine.

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Competent Medical School Faculties Key To Strong Profession, I.U. Speaker Says

"THE MEDICAL PROFESSION has much to gain if our program of medical education remains vigorous and strong; it has much to lose if our medical schools are weakened."

That was the warning given May 9 to alumni of the Indiana University School of Medicine during their ninth annual Alumni Day program by Dr. Joseph C. Hinsey, director of the New York Hospital-Cornell University Medical Center and past president of the Association of American Medical Colleges, recognized as one of the foremost authorities on today's problems of medical education.

"While it has been my experience that many physicians of prominence in their own communities know little about the activities of their own medical schools," Dr. Hinsey continued, "I have found that such a condition does not prevail here and I am confident that the alumni as well as the students are being briefed as to the problems that face your administration. The problems are complex and difficult and must be faced with fairness and equanimity. All of us are in this together and must work it out in such a manner that the teaching of our future physicians and the members of allied health professions is maintained at a high level and advanced whenever possible."

In closing Dr. Hinsey said, "The medical profession is helping our medical schools through the American Medical Education Foundation and the National Fund for Medical Education. Your help will be even more substantial if you continue to help make it possible for medical schools to remain strong by recruiting and holding competent faculties."

DEAN MAKES REPORT

Closing speaker on the Alumni Day program was Dean John D. VanNuys of the School of Medicine, whose annual report to the alumni covered progress on the construction of the new medical science building, plans for additional housing for students and staff, plans for



Members of the 1906 class graduated from Indiana Medical College (later incorporated into Indiana University School of Medicine). The 1906 class was given special recognition of the Alumni Day program.



Scene under the "Big Top" during the traditional fried chicken and strawberry shortcake picnic of I. U. Medical School alumni. Approximately 600 registered for the reunion on the Indianapolis Medical Center campus.

erection of a new adult hospital, the problems involved in the transfer of the first year of medicine from Bloomington to the Medical Center campus, and the study of the curriculum now in progress.

Dean VanNuys paid a high tribute to President Wells and other University officials for their encouragement of the medical school expansion and to the heads of neighboring hospitals—Indianapolis General, Larue D. Carter, and Veterans—for their cooperation in expanding the Medical School's teaching program.

600 ATTEND REUNION

More than 600 alumni were registered for the day's activities which opened with a fried chicken and strawberry shortcake picnic under a big tent. Special recognition was given to members of the five-year reunion classes, those of 1911, 1916, 1921, 1926, 1931, 1936, 1941, 1946 and 1951. Additional honors were given to members of the 1906 graduating class of Indiana Medical College, which shortly afterwards became a part of the I.U. School of Medicine.

During an afternoon business meeting, conducted by Dr. Norman R. Booher, president of the medical alumni group, committee reports were presented and a brief tribute was paid to the 32 alumni whose deaths had been reported during the year.

OFFICERS ELECTED

Nominated as officers for the 1957-58 year and to be installed at the 1957 meeting which will be held in September as a part of the dedication of the new Medical Science building, were: President, Dr. Seth Ellis, Anderson; vice president, Dr. Robert Smallwood, Bedford; secretary, Dr. Olga Booher, Indianapolis; treasurer, Dr. Donald J. White, Indianapolis, and, historian, Dr. Frank Forry, Indianapolis. Drs. Booher, White and Forry were renamed for additional terms.

Named to the alumni council for three-year terms starting next year were: Dr. Fred R. Malott, Converse; Dr. William C. Heilman, Newcastle; Dr. Carl M. Davis, Valparaiso, and Dr. William R. Clark, Fort Wayne. To serve one-year terms are Dr. Malcolm O. Scamahorn, Pittsboro and Dr. Charles Snyder, Evansville. Dr. Maurice E. Glock, Fort Wayne, was named to succeed Dr. Lester D. Bibler, as the medical



Dr. Edwin N. Kime accepts the gavel as president of the I. U. School of Medicine Alumni Association from Dr. Norman R. Booher, retiring president, during the Ninth Annual Alumni Day program on May 9.

group representative on the executive council of the I.U. Alumni Association.

Installed as officers for the 1956-57 year, during the business meeting, were: Dr. Edwin N. Kime, Indianapolis, president; Dr. Joseph B. Davis, Marion, vice-president; Dr. Olga B. Booher, Indianapolis, secretary; Dr. Donald J. White, Indianapolis, treasurer; and, Dr. Frank Forry, Indianapolis, historian. Beginning terms on the council were: Dr. Richard W. Emme, Fort Wayne; Dr. William R. Tindall, Shelbyville; Dr. H. Dale Pyle, South Bend; Dr. Dennis S. Megenhardt, Indianapolis; Dr. Joseph M. Black, Seymour; and Dr. Fred R. Malott, Converse.

Dr. Booher, retiring president, was presented with a certificate of appreciation by the I.U. Alumni Association, for his efforts in enlarging the medical alumni membership, and Dr. J. J. Mahoney was honored by the medical group for his assistance in staging the annual meeting.

A musical program, opening the afternoon session, was given by two groups of students from the Bloomington campus, the Hoosier Queens and the Male Quartet.

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*Moyer, J. H., and Hughes, W. M.:
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Deaths . . .

Robert J. Buckman, M.D., 53, died April 12 at his home in Charlestown.

Dr. Buckman came to Indiana in 1953 to serve as physician for the Goodyear Engineering Corporation at the Indiana Arsenal, Charlestown. He had previously been with Parke, Davis & Company, Detroit. Dr. Buckman was a 1930 graduate of University of Louisville School of Medicine.

He was a member of Clark County Medical Society, the Indiana State and American Medical Associations.

John Hugh Williams, M.D., who had been in the general practice of medicine in Muncie since 1928, died in his home there May 12. He had closed his office last August because of ill health. Dr. Williams was 76.

A native of Shawnee, Ohio, Dr. Williams attended the University of Maryland and Ohio State University, receiving his medical degree from Starling Medical College at Columbus (Ohio State University) in 1907. He entered the medical profession at Waynesburg, Ohio where he practiced for two years. He then spent 19 years in Cowan before establishing his practice in Muncie. Dr. Williams served two terms as Delaware county coroner and five years as Muncie city health officer.

He was a senior member of Delaware-Blackford County Medical Society, the Indiana State and American Medical Associations, and was also a member of the American Academy of General Practice.

Eva Joanne Buxton, M.D., 92, who practiced for more than 50 years in Rockport, died May 14 in West Memphis, Arkansas, where she had lived for several years with a niece. Before entering medical school, Dr. Buxton taught school and was in nurse's training in Louisville.

Dr. Buxton received her medical degree from Northwestern University Women's Medical School, Chicago, in 1897. She spent her entire career caring for several generations of Spencer county families.

Dr. Buxton was a senior member of Spencer County Medical Society, a Fifty Year Club member of Indiana State Medical Association and an associate member of American Medical Association.

Rudolph A. Mehl, M.D., 50, died in his Evansville home May 21 after a 10-day illness.

Dr. Mehl was a native of West Allis, Wisconsin. He received his degree in medicine from Emory University School of Medicine, Georgia, in 1931 and practiced in Milwaukee before establishing his practice in Evansville 19 years ago. He served as plant physician for an Evansville industry before entering private practice as a physician and surgeon.

Dr. Mehl held membership in church, social and lodge organizations. He was a member of Vanderburgh County Medical Society, the Indiana State and American Medical Associations.

Jacob O. McCracken, M.D., 81, died at Daviess County Hospital on May 12. The oldest physician in the county, Dr. McCracken had practiced in Montgomery until four months ago.

Born in Daviess county, Dr. McCracken attended the Medical College of Indiana at Indianapolis. He received his degree there in 1905 and went to Kenosha, Wisconsin, where he practiced until 1938. Since that time he had been in practice in Montgomery.

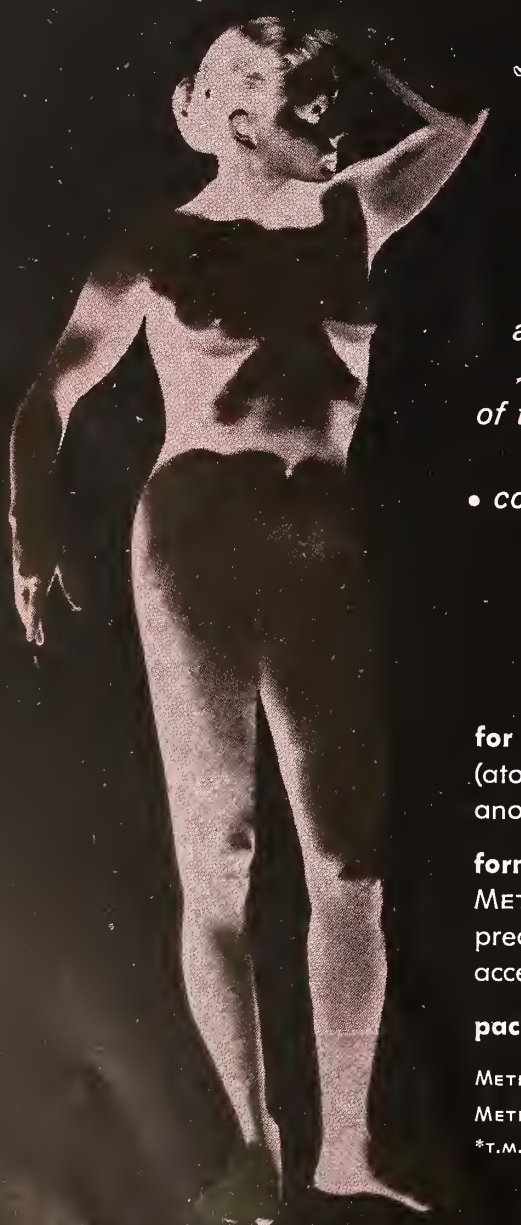
Dr. McCracken was a member of Daviess-Martin County Medical Society, a senior and Fifty Year Club member of Indiana State Medical Association, and associate member of American Medical Association.

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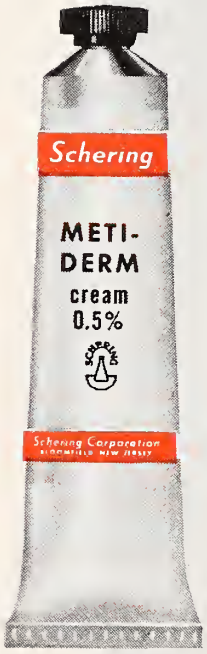
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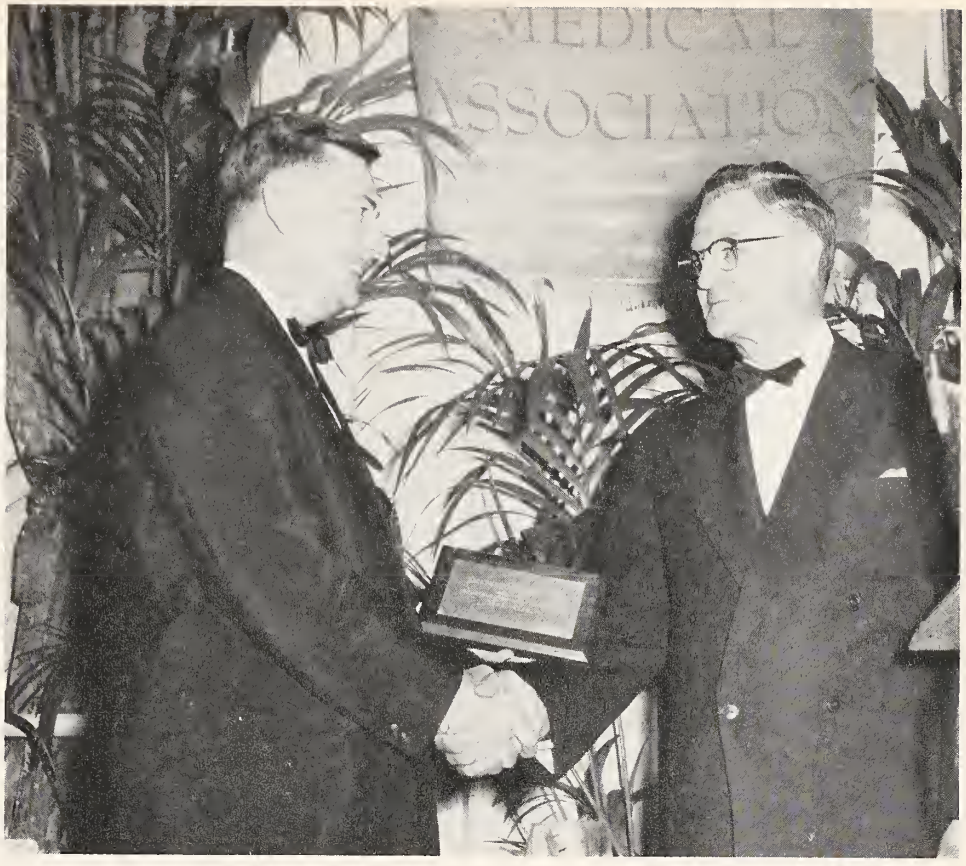
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Dr. Kieffer Davis of Bartlesville, Oklahoma, immediate past president of the Industrial Medical Association, congratulates **Dr. E. J. Jones**, Hammond, Indiana, his successor as president of IMA. Dr. Jones was installed at the annual banquet in Philadelphia April 25.

Dr. E. S. Jones Heads Industrial Medical Association; Other Hoosiers Honored

AN INDIANA INDUSTRIAL PHYSICIAN, Dr. E. S. Jones, Hammond, assumed the presidency of the Industrial Medical Association at the forty-first annual meeting of the organization in Philadelphia on April 25. He also served as general chairman for the conference.

Dr. "Jack" Jones is a delegate from the Indiana State Medical Association to the American Medical Association and has served as a member or chairman of the Committee on Industrial Health of ISMA for 10 years.

As president of the 3,300 industrial physicians of the IMA he will play an important role on the national scene during the coming year.

Dr. H. Glenn Gardiner, East Chicago, was reelected secretary, Dr. Emmett B. Lamb, Indianapolis, was named a director of the IMA; and Dr. Allan K. Harcourt, Indianapolis, was named councilor for District 15, composed of Illinois and Indiana.

Indiana physicians who became Fellows of the Industrial Medical Association at the annual meeting were Merrill P. Benoit, Anderson; Joseph C. Donchess, Gary; F. Minton Hartz, Evansville; James D. Pierce, Indianapolis, and B. Kemper Westfall, Indianapolis.

Other industrial specialty organizations met in Philadelphia simultaneously with IMA.

At the American Conference of Government Industrial Hygienists Dr. Louis W. Spolyar, director of the division of industrial hygiene, Indiana State Board of Health, served as convention chairman.

Dr. Walter U. Kennedy, New Castle, president of the Indiana State Medical Association, and James A. Waggener, executive secretary, represented the State Association at the Philadelphia meeting.

NEWS NOTES—from State and Nation

Blue Cross Enrollment in 1955 Record for Last Five Years

The largest enrollment growth since 1950 was recorded by Blue Cross Plans during 1955, according to a report for the year issued at the annual conference of Blue Cross Plans.

The enrollment of 3,726,899 persons in the hospital prepayment program was accomplished during the year. The fourth quarter enrollment of 1,150,696 was the largest fourth quarter advance since 1946 and the second largest in the 26-year Blue Cross history.

At the end of 1955, total Blue Cross enrollment was recorded at 51,329,940 people, almost one out of every three persons in the United States.

Dr. Arnold H. Duemling, who retired from surgical practice in Fort Wayne three and one-half years ago, because of illness, has completed a two-year residency in dermatology at Cook County Hospital, Chicago. He has now returned to Fort Wayne where he has opened an office for the practice of dermatology in the Weyrick Building, Covington Road at Time Corners. A severe sciatica necessitated Dr. Duemling's temporary retirement. Dr. Ben Leming replaced Dr. Duemling on the surgical staff at Duemling Clinic, Fort Wayne.

Dr. Warren Niccum, Columbia City, was notified during March of his certification by the American Board of Pediatrics. He has been associated with the Linvill Clinic for three years.

The 34th annual scientific and clinical session of the **American Congress of Physical Medicine and Rehabilitation** will be held Septem-

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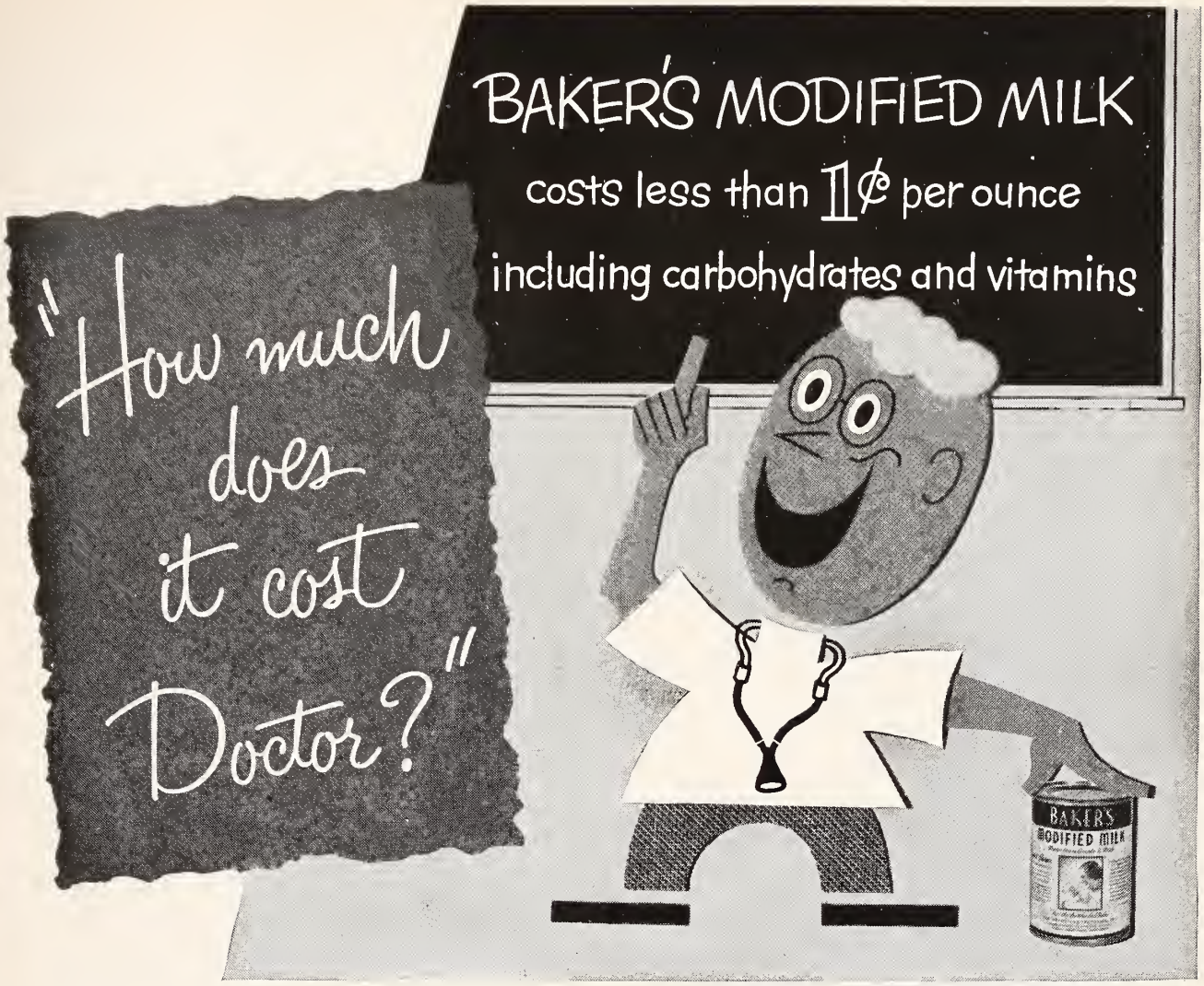
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ber 9-14, 1956, inclusive, at The Ambassador, Atlantic City.

Scientific and clinical sessions will be given September 10, 11, 12, 13, and 14. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

Indiana Psychiatrist Heads Private Hospital Group

Dr. Philip B. Reed, director of psychiatric education at Norways Foundation Hospital, Indianapolis, assumed the presidency of the National Association of Private Psychiatric Hospitals on April 29 at the Association's annual meeting in Chicago. He is the first Indiana physician to hold that position. He was elected by mail ballot from the 125 member hospitals.

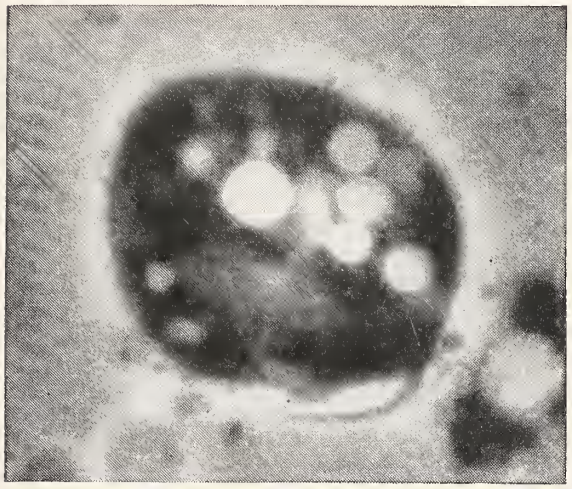
The private psychiatric hospitals represent only 2.7 percent of the psychiatric beds in the United States but account for 23.7 percent of all first admissions for mental illness.

Dr. Reed has been president of the Indiana Neuropsychiatric Association, the Central Neuropsychiatric Association and the Electroshock Research Association. He is serving as chairman of the 1956 fund drive of the Marion County Association for Mental Health.

Dr. George N. Love, Indianapolis, was recently certified by the American Board of Anesthesiology, according to an announcement by Dr. C. B. Hickcox, secretary of the Board.

Dr. Philip Bowser, who had been in practice in Goshen since July 1955, closed his office there March 31 and reported for active duty as a first lieutenant in the medical corps reserve

DAVIS TECHNIQUE USING VAGISEC® JELLY AND LIQUID EXPOSES AND EXPLODES TRICHOMONADS HIDDEN AWAY IN RUGAE



Phase-contrast microscope shows a trichomonad in a mucinous vaginal smear.

MANY trichomonacides failed in years past largely because they reached only the parasites swimming freely in the vaginal canal—not those hiding under epithelial cells deep among the vaginal rugae. In fact, some agents actually coagulated the albuminous material lining the surface and protected the trichomonads![1]

Success at last. Today, however, you can overcome this problem because VAGISEC jelly and liquid quickly penetrate to trichomonads' hideaways. You can now treat vaginal trichomoniasis successfully, using the Davis technique. Carl Henry Davis, M.D., eminent gynecologist and author, and C. G. Grand, research physiologist, introduced VAGISEC liquid as "Carlendacide" and had it tested by over 100 well-known obstetricians and gynecologists. Dr. Davis states, ". . . over 90% of apparent cures have been obtained. . . ."[2]

Overpowering action. A chelating agent and two surface-acting agents in VAGISEC liquid, combined in balanced blend, not only reach trichomonads but explode them![3] The three chemicals act to weaken the parasites' cell membranes, to remove waxes and lipids, and to denature the protein. With their cell walls destroyed, trichomonads imbibe water, swell and explode.

The Davis technique.† Dr. Davis recommends a combination of office treatments and home treatments, using both VAGISEC jelly and liquid in home treatments. "A few women have infected cervical, vestibular or urethral glands and require other types of treatment. . . ."[2] It is well to remember the role of the male as carrier of the organism and prescribe protection against re-infection from the husband.[2]

Office treatment. Expose vagina with speculum. Wipe walls dry with cotton sponges and wash thoroughly for about three minutes with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton sponges. Dr. Davis recommends six office treatments, three the first week, two the second, and one the third.

Home treatment. Patient douches with solution of VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Treatment is continued through two menstrual periods, but is omitted on office treatment days. Continued douching two or three times a week after therapeutic success helps prevent re-infection. Douching is contraindicated in pregnancy.

Summary. The unique action of a combination of three agents comprising VAGISEC liquid reaches and explodes hidden as well as surface trichomonads. This therapy has a high rate of success and results in fewer flare-ups. VAGISEC jelly and liquid are non-toxic and non-irritating, and leave no messy discharge or stain.

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Active ingredients: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

1. Davis, C. H.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954.
2. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955.
3. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955.

at Brook Army Hospital, San Antonio, Texas, where he was to serve five weeks before reassignment.

Dr. J. William Wright, Jr., Indianapolis, has been named one of the four new members of the Auxiliary Board of the Alexander Graham Bell Association for the Deaf. The May issue of *Volta Review* carries a photograph and biography of the Indiana physician.

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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The Indiana Alumni Association of Phi Chi medical fraternity held a two-day meeting March 30 and 31 in the Columbia Club, Indianapolis. Dr. Max S. Norris, Indianapolis, is president of the association.

Lieutenant Governor Harold W. Handley spoke at the annual banquet. Jacob E. Reish, editor of Phi Chi's magazine, also spoke and awards were presented to undergraduate medical students.

The office of **Dr. J. M. Kercheval** was destroyed in a fire which razed the Clinton Hotel building in Clinton March 28. Firemen were able to save Dr. Kercheval's medical library after donning masks, however all other equipment was lost.

Dr. Adolph Weinstock recently moved into his new office building in Rolling Prairie. Constructed adjacent to his residence, the new building has two examining rooms, an X-ray room, laboratory and drug room, private office and a waiting room. Dr. Weinstock has practiced in Rolling Prairie for 10 years.

Members of the senior class at Indiana University School of Medicine attended an indoctrination session February 21 when they received instructions on requirements for licensure from Miss Ruth V. Kirk, secretary of the Indiana State Board of Medical Registration and Examination; heard Wilbur Penberthy, federal narcotics agent, speak on the handling of narcotics; learned of the functions and benefits of membership in a county medical society from a talk by Joseph E. Palmer, secretary of Indianapolis Medical Society, and of membership in the state and national medical associations by James A. Waggener, executive secretary of Indiana State Medical Association. Dr. Henry K. Nester, Indianapolis public health official, outlined the importance of proper filing of birth and death certificates and discussed medical and legal aspects of performing autopsies. A question and answer period followed with Dr. Don E. Wood in charge.

Dr. J. V. Schetgen, who has been in practice in Geneva for several years, is building a new office north of Geneva. Construction was started during March.

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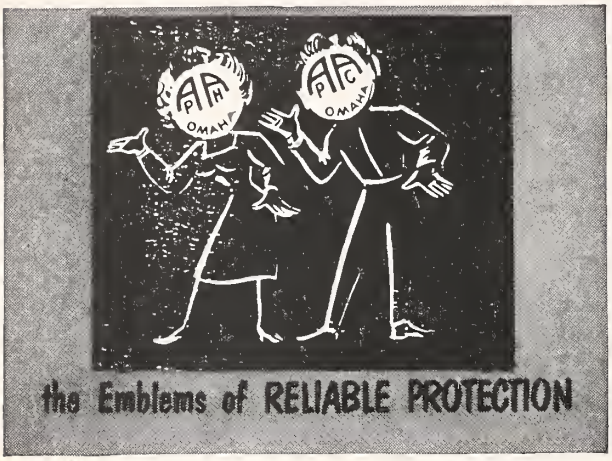
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2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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Huntingburg Doctor Speaks on Socialized Medicine to Kiwanians

Dr. A. B. Scales, Huntingburg, spoke to members of the Kiwanis club of that city at a March meeting. A member of the club, Dr. Scales discussed "Socialized Medicine" from the time of its inception in 1793 and warned of eventualities should such a form of health care be adopted in the U. S. He said it "would mean hordes of administrative forces; greater possibilities for politicians; fewer young men interested in medicine as a profession; a general degradation of the profession; many groups still will not be taken care of, and all other businesses and professions will be socialized, leading to national catastrophe."

Dr. Scales, revealing some of the characteristics of the socialized medicine program in England, said the average doctor there must see 100 patients per day for an annual salary of $4,000.

Dr. Jean A. Creek has opened offices for the general practice of medicine at 312 North Walnut street in Bloomington. He has served since last July on the staff of Indiana University Health Service. Dr. Creek is a native of Evansville, 1952 graduate of I. U. School of Medicine and served his internship at Long and Riley Hospitals, Indianapolis. He served from July 1953 to July 1955 in the U. S. Army Medical Corps, stationed at Fort Devens, Massachusetts, and in Paris, France on the staff of the American Hospital.

Dr. and Mrs. Creek and their daughter have been living at 607 North Fess in Bloomington since returning from France.

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Michigan State Society Plans Conference on Aging

The Conference on Aging to be held in Ann Arbor, July 9-11, 1956, will deal with the topic "Health for the Aging, Medical and Social Services." It is being planned by members of the Geriatrics Committee of the Michigan State Medical Society, the Departments of Postgraduate Medicine and Gerontology of the University of Michigan.

A large part of the meetings will be devoted to clinics for doctors of medicine dealing with specific diseases in elderly patients. There also will be groups dealing with the many other problems in the gerontologic field—e.g., geriatrics education in medical schools and hospital training programs; the many social and psychologic aspects of the older person; rehabilitation of the physically and mentally handicapped, as well as a consideration of the standards and activities in nursing homes and homes for the aged. In each group there will be persons of experience and ability so that a highly successful and stimulating conference will be assured.

Research Seminars will also be held at which the biologic aspects of aging, medical research problems and the social-psychologic viewpoints will be discussed by outstanding research scientists of national reputation.

Final program will be available in the June issue of the Journal, Michigan State Medical Society.

For information contact A. Hazen Price, M.D., Chairman, Michigan State Medical Society, Geriatrics Committee, 62 W. Kirby Ave., Detroit 2, Michigan.

The American Goiter Association held its annual meeting in Chicago on May 3, 4 and 5. Thirty-eight papers covering physiology and diseases of the thyroid gland were read. Physicians from Indiana attending the meeting included Drs. James O. Conklin and William O. Baldridge of Terre Haute, Dr. Michael Shellhouse of Gary, and Drs. Goethe Link, L. H. Kornafel, Arthur B. Richter, Frank B. Ramsey, Glenn W. Irwin, Robert F. Nagan, S. W. Morgan, and James D. Finfrock of Indianapolis.



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Indiana Men Play Prominent Roles at Chest Physicians' Meeting

Dr. James H. Stygall, Indianapolis, president of the American College of Chest Physicians, presided at the 22nd annual meeting of the College June 7 through 10 in the Hotel Sherman, Chicago. The meeting marked the close of his term of office.

The first Louis Mark Memorial Lecture was given at an evening meeting June 7 by Dr. Leroy E. Burney, Assistant Surgeon General, U. S. Public Health Service. His subject was "What Can the Public Health Service Contribute to the Private Practice of Medicine?" Dr. Burney was formerly Indiana Health Commissioner and secretary of the State Board of Health.

Others who participated in the scientific programs were Dr. John V. Thompson, Indianapolis thoracic surgeon, who discussed "Surgery in Lung Tumors" at the Fireside Conference; and Dr. George S. Bond, professor emeritus, Department of Cardiology, Indiana University School of Medicine, who spoke on "The Problem of the Heart in Kyphoscoliosis".

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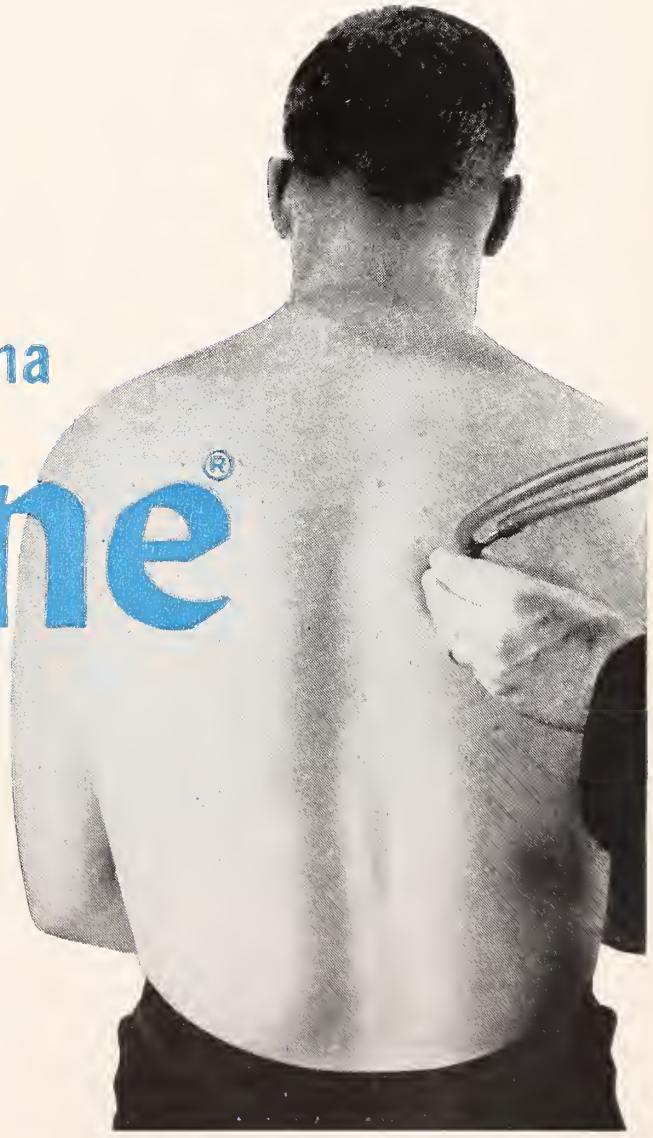
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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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Abstracts:

SYMPOSIUM ON THE LUNG

Note: The following abstracts are of papers in a Symposium on the Lung published in Minnesota Medicine, Vol. 38, No. 9, 1955.

I. OBSERVATIONS ON THE HISTORY OF THE BRONCHOPULMONARY SEGMENTS

Boyden, Edward A., Ph.D., Seattle, Washington.

The history of pulmonary function and anatomy is reviewed beginning with the anatomical studies of Aeby in 1878 in Bern. This dates the first real studies that revealed the asymmetry of the tracheobronchial tree and centered attention upon the developments in the two lungs. Ewart of London brought an intimate understanding of the anatomy to the clinical concept of pulmonary diseases and attempted to correct previous errors. Much of the anatomical study concerned itself with a comparison of the human to other mammals and the surgery of the lung had to wait for improvement in anesthesia and the control of infections. Later Glass in New York succeeded in locating pathology adequately by segments of the lungs and has made possible segmental surgery of the lung.

II. PULMONARY-FUNCTION TESTS

Ward S. Fowler, M.D., Rochester, Minnesota.

Disturbances in pulmonary function may be the result of pathological processes that involve any of the essential respiratory mechanisms from the respiratory center in the brain to the pulmonary capillary circulation in the lungs. To evaluate any respiratory function it is essential to interpret the test in the light of the history of the development of symptoms and other observations of the patient before, ability to handle oxygen, and to estimate the ventilatory capacity. The most practical tests are the easiest to be done. Three tests are suggested:

1. The vital capacity is simply the measurement of the amount of air that can be exhaled after deep inspiration.

2. The speed of expiration may be tested and any marked alteration in the speed may be found in any disease that reduces the free flow of air through the bronchial tree as in asthma and emphysema. Any disease that interferes with normal lung expansion or contraction may be expected to cause abnormal tests following expiration.

3. The maximal breathing capacity may be determined by the amount of nitrogen left in the alveolar air after breathing oxygen for seven minutes and then testing the expired air for nitrogen. Under normal concentrations the nitrogen will be less than 2.5 per cent. If a large quantity of residual air is trapped in the lungs, and if this residual air does not move, the nitrogen content will not be reduced.

III. CLINICAL IMPORTANCE OF HYPERCAPNIA

E. B. Brown, Jr., and Fletcher Miller, Minneapolis, Minnesota.

Most respiratory deaths are due to lack of oxygen but there are certain conditions of clinical importance in which carbon dioxide cannot be exhaled—hypercapnia. About 1950 Beecher made some studies on the carbon dioxide content of blood during surgery and it is known that the carbon dioxide may rise slowly during surgery even with an adequate supply of oxygen. Profound cardiovascular changes may take place during rapid fall of carbon dioxide after operation and this may be the cause of postoperative hypotension, cardiac arrest, and ventricular fibrillation. Suggestions are made to avoid respiratory accidents and if it develops in spite of protective efforts then the hypercapnia should be relieved slowly.

IV. ACUTE PULMONARY EDEMA

Mark D. Altschule, M.D., Boston, Massachusetts.

Acute pulmonary edema is not always due to left heart failure. Several observations suggest that other natural causes may so affect the pulmonary fluid balance that acute swelling of the lungs may occur occasionally without heart failure. Two changes suggested are vasomotor changes and pulmonary hypertension.

Suggested treatment includes the ordinary treatment for acute cardiac edema.

V. IDIOPATHIC PLEURAL EFFUSION

Robert G. Rossing, M.D., Minneapolis, Minnesota.

When the pleura is found to have fluid in it tuberculosis is always to be suspected. The onset may be associated with fever and pain and tuberculosis can be demonstrated in only about 25 per cent of the cases but if the tuberculin test is positive the diagnosis is likely to be tuberculosis. Other causes of pleural fluid are not to be overlooked but the treatment of effusion is rest and aspiration and the management of the underlying disease.

Robert Sanderson, M.D., South Bend.

EMERGENCY MANAGEMENT OF THORACIC TRAUMA

Strug, Lawrence, H., M.D., and Leon, William, M.D., New Orleans. Journal of the Louisiana State Medical Society, Vol. 107, No. 12, December 1955.

This article is a comprehensive classification and detailed recommendation for the care of trau-

matic injuries to the chest. It is a timely article in view of the increasing number of injuries as a result of the increased power and speed associated with our highways and industries. The authors have emphasized the basic pathological entities which have to do with the disturbance of exchange of oxygen and carbon dioxide in the respiratory tract, and the factors which influence this exchange. These are classified as:

(1) Retain bronchial secretions, (2) Instability of the chest wall, (3) Sucking wounds of the chest, (4) Hemothorax and its complications, (5) Pneumothorax.

Transportation to a medical center and early care of the patient is emphasized as is the early evaluation of the chest injury itself.

Emphasis is placed on early tracheotomy and early recognition of pneumothorax and hemopneumothorax. Persistent aspiration, until the lung is completely expanded, is also emphasized. Fractures of the sternum and ribs and their treatment are discussed, and special attention to injury of the heart and large vessels is recommended. Mention is made of the removal of foreign bodies in excess of 1½ cm. in size at the appropriate time. The abdomino-thoracic injuries have been reviewed with suggestions in regard to combined injuries and special attention to perforations of the intestinal tract and injuries to the larger upper abdominal organs with bleeding. Esophageal injuries of spontaneous nature do occur, but rarely are they associated with injuries at the time of the accident. These most commonly follow the explosive type of vomiting in which the cricopharyngeal muscles do not release in time for the expulsion of the abdominal contents. Diaphragmatic tears with displacement of intestinal organs are likewise to be evaluated, these may require X-ray examination for identification.

The article has covered the subject well, but the reviewer disagrees with the writer who does not encourage x-rays at the time of admission, since the x-ray department is usually near the emergency ward. The x-ray examination is important to establish a base line for detecting any changes which might occur in the chest thereafter. Even this examination can be made with a minimal amount of disturbance to the patient with a portable machine. Lastly, the reviewer would recommend caution in the possible overloading of a damaged lung with plasma or whole blood in the treatment of shock.

This article could well be kept accessible in each emergency ward for the house staff to refer to as a continual source of information.

The general information in the article is informative and clear and very much worth one's time for study and re-reading.

K. E. Selby, M.D., South Bend.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

The Council

April 29, 1956

The Council of the Indiana State Medical Association convened for its spring meeting at 10:00 a.m., Sunday, April 29, 1956, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Kenneth L. Olson, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Minor Miller, Evansville
Second District—J. H. Crowder, Sullivan; Sam I. Rotman, Jasonville, alternate
Third District—Keith Hammond, Paoli; John M. Paris, New Albany, alternate
Fourth District—J. E. Dudding, Hope
Fifth District—M. C. Topping, Terre Haute; V. Earle Wiseman, Greencastle, alternate
Sixth District—Harry P. Ross, Richmond; William R. Tindall, Shelbyville, alternate
Seventh District—Lester D. Bibler, Indianapolis
Eighth District—Guy A. Owsley, Hartford City; Gordon B. Wilder, Anderson, alternate
Ninth District—Wemple Dodds, Crawfordsville; H. E. Klepinger, Lafayette, alternate
Tenth District—James P. Vye, Gary
Eleventh District—Max R. Adams, Flora
Twelfth District—Maurice E. Glock, Fort Wayne
Thirteenth District—Kenneth L. Olson, South Bend; G. O. Larson, LaPorte

Officers:

Walter U. Kennedy, New Castle, president
O. W. Sicks, Indianapolis, treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor
David A. Bickel, South Bend, associate editor

Executive Committee:

James W. Denny, Indianapolis, chairman
E. H. Clauser, Muncie
Albert Stump, attorney
Robert Hollowell, attorney
Robert J. Amick, field secretary
Kenneth W. Bush, field secretary
J. A. Waggener, executive secretary

Guests:

James M. Leffel, Indianapolis, chairman, Committee on Convention Arrangements
Don E. Wood, Indianapolis, co-chairman, Committee on Public Policy and Legislation
James W. Crain, Williamsport, chairman, Committee on Veterans Affairs and Rehabilitation
Glenn Irwin, Indianapolis
Jene R. Bennett, South Bend, State Representative from Indiana on North Central District Blood Bank Clearing House
C. T. Dutchess, Galveston, R. W. Kuhn, Wilkinson, members, Sub-committee on Preceptorships

On motion of Drs. Miller and Glock, the minutes of the January 15, 1956, Council meeting were approved as printed in the March 1956 issue of THE JOURNAL.

REPORTS OF COUNCILORS

The councilors announced the dates and places of their spring district meetings and invited the officers and councilors to attend these meetings. They also suggested the following members as observers on the Indiana University Medical School Admissions Committee:

From:

First District—Charles P. Schneider, Evansville
Second District—M. M. McDowell, Vincennes
Third District—Donald M. Kerr, Bedford
Fourth District—J. E. Dudding, Hope
Fifth District—William G. Bannon, Terre Haute
Sixth District—Robert W. Kuhn, Wilkinson
Seventh District—Norman R. Booher, Indianapolis
Eighth District—Wendell E. Covalt, Muncie
Ninth District—James M. Kirtley, Crawfordsville
Tenth District—James B. Burcham, Gary
Eleventh District—Donald K. Winter, Logansport
Twelfth District—C. W. Dahling, New Haven
Thirteenth District—Harold D. Pyle, South Bend

Dr. Glock, chairman of the Committee on Medical Education and Licensure, explained that the purpose of having observers on the Medical Admissions Committee is to acquaint physicians out in the districts on the procedure followed in selecting applicants for admission to the medical school. "Some time ago one of the doctors in my district suggested that we ask the medical school to enlarge the membership of its Admission Committee. I went to John VanNuys and asked him if it would be possible to have active members on the Admissions Committee from practicing physicians in the state. He told me that was impossible. Then we went to him later and asked to have observers who would sit in on the Admissions Committee meetings, to watch the interviews and to have the opportunity to ask questions. Now the reason for that was not to try to dictate to the Admissions Committee but to enable these observers from throughout the state to go back into their areas and explain the procedure in their district. I think if the average doctor in the state knew the care and the effort that goes into selecting the candidates for admission to medical school that we would quit getting the complaints that we get. Our committee is very pleased that the school has opened up this committee to observers.

"The committee has a number of meetings and it would make it unwieldy to have the whole group in every time. They will rotate the observers so that representatives from all parts of the state will have an opportunity to observe and see how students are selected. The observers will not have a vote and they will not have the right to interrogate any of the candidates, but they will have the right, when the candidates are not before the committee, to ask questions and ask why did you select this man and why did you turn this man down. We felt it would be better relations for the

medical school with the medical profession in the state if that were done, and I am very happy to see that they have accepted this."

Dr. Bibler reported that the Indianapolis Medical Society had gone on record as against adopting any type of fee schedule at this time. "I think there will be a resolution presented at the fall meeting relative to this item."

Dr Dodds questioned the advisability of publishing in THE JOURNAL openings in the state for physicians, and the headquarters office acting as a placement bureau, without first thoroughly investigating the community in which the need for a physician apparently exists. Dr. Dudding and the executive secretary stated that the placement service is a part of the Rural Health Committee's program and in every case the committee endeavors to get all the facts on all locations reported to the headquarters office. This activity of the Rural Health Committee has been approved by the House of Delegates.

REPORTS OF OFFICERS

Dr. O. W. Sicks, treasurer, reported that in the last five months $58,000.00 from the Medical Defense and General funds had been invested in United States Treasury bonds, with interest income from these bonds approximating $1,600.00 per year. Investments of the Association now total $234,000.00, with annual interest income of approximately $7,000.00.

Student Loan Fund. Dr. Sicks, Dr. Denny, and the executive secretary discussed the present status of the Student Loan Fund, saying that as soon as the necessary printed forms are available and any applications are approved, the $10,000.00 authorized by the House of Delegates will be transferred to a special Student Loan Fund and the fund put into operation. To date, three applications have been received by the headquarters office.

Dr. Frank B. Ramsey, editor of THE JOURNAL, announced that the Editorial Board was meeting at this time and would have lunch with the Council members.

LEGISLATIVE MATTERS

Dr. Don E. Wood, co-chairman of the Committee on Public Policy and Legislation, reported that his committee was scheduled to meet in formal session on Sunday, May 6, 1956. "In the interim the Legislative Committee in part, with other members of the Association, is going to Washington to meet with your Congressmen and their secretaries at the annual Chamber of Commerce meeting there this week, and we hope to be able to supply you with some information concerning pending legislation."

UNFINISHED BUSINESS

1. *American Medical Education Foundation Fund.* Dr. Glock, chairman of the Committee on Medical Education and Licensure: "As you know, we are just concluding National Medical Education Week and there should have been a drive conducted in all of your communities, both through the doctors and through the general public. I have a letter here from the executive secretary of the Marion (Indianapolis) County Medical Society that I would like to read to you to show you what one county has accomplished. This is a letter to Mr. Leo Brown, director of Public Relations of the A. M. A.:

As requested in your memorandum of April 18, here is a report and publicity enclosures on Medical Education Week in Indianapolis. Incidentally, we would appreciate return of the enclosures if possible after you have finished with them.

TELEVISION

We had two one-half hour shows entirely devoted to Medical Education Week, all public service time. One was held at 2:30 p.m., April 22, on WFBM-TV and consisted of a showing of the film, "Danger at the Source," with fill-in the rest of the time where the local Society's PR chairman interviewed the dean of the Indiana University School of Medicine. The interview covered the waterfront on local and national medical education.

The other show was on WISH-TV and consisted of a panel of four doctors with our PR chairman as moderator. Each doctor was assigned a specific subject; i.e., pre-med, medical education itself, research and post graduate education. All phases were covered and it was quite well received as was the other one.

Incidentally, our regular TV panel show, "Ask Your Doctor," won the top award for both the station, WISH-TV, and for the moderator, Mr. Al Vare, from the local Health and Welfare Council. The awards were made at a public ceremony attended by the mayor and other civic and governmental dignitaries. These awards are much coveted. It extended over 26 weeks.

RADIO

We had one half-hour show and one 45-minute show plus two 15-minute shows, all on different stations. They were of the panel-type, interview variety. On one show we used a senior medical student to get the student's slant. Other participants were doctors, Ph.D's at the Medical School and the like. We heard nothing but the most favorable comment.

NEWSPAPERS

We started off the week with a long, feature-length article in the magazine section of the Indianapolis Sunday Star and a copy is enclosed. The editor said we could have about any space needed if we'd write the story so we did.

Our leading columnist, Mickey McCarty, devoted one entire column to the week. Copy enclosed.

We provided releases to all weekly papers in the county—15 and we are enclosing a clipping of a typical play (on the front page, too!)

"Straight" news matter also is enclosed, as well as an editorial in our leading morning paper.

We obtained two other lengthy feature articles, one dealing with medicine as a career and another with our Medical Auxiliary's activities.

We purchased advertising space in all three dailies on the radio and TV page to call attention to our radio and television shows.

CLUB SPEAKERS

We sent letters to all major luncheon and civic clubs and landed speakers in ten of them. We would have had more if we had been smart enough to circularize them last summer before the year's programs were set, but even so we did okay and the response was very, very good. Doctors and the undersigned carried the load here. We distributed the AMA pamphlet, "What's Up," at the meetings. Generally speaking, the question period was longer than the speeches, showing public interest in medical education.

OTHER ACTIVITIES

Our Auxiliary had a sell-out house at our Civic Theater (local theater group) for the "Seven-Year Itch" and all proceeds were given to AMEF.

We re-solicited all doctors for contributions to AMEF.

All in all, we feel we had a successful week. At least a lot of people have been talking about it and a lot more were exposed to it.

All activity was directed by a sub-committee of our public relations committee reinforced by newspaper people, civic leaders, etc. It was a small group and we tried to get them in a good mood with a free steak dinner, some martinis and the like.

"I would like to commend this local society for the terrific job that they have done. . . . This is a continuing program and our goal, of course, is to try to get contributions from 100 per cent of our Indiana physicians. Vigo county passed an assessment and that county is 100 per cent; Putnam county is also 100 per cent. The big question is should we or should we not consider going into assessments on a county level, or whether we should consider it on a state level. It seems that the consensus of opinion is that we do not want assessments on a state level.

"I would like to give you a report on the funds that have been available since this started back in 1951:

"Indiana University has received $128,043.00.

"At the present time $95,189.71 are deposited in the Trust Fund for the school.

"As of January 31, 1956, the value of the Fund was $110,106.13, with an unrealized gain of $21,456.17.

"As of April 30, $7,998.50 has been received during 1956.

"We are going to have a follow-up program the rest of the year, attempting to get in touch with every doctor in the state who has not given and see if we can't convince them of the value and the worth of this program and ask them to give.

"An interesting thing occurred this month, worthy of mention. As you all probably recall, the Ford Foundation allocated $90,000,000 for medical education to the various medical schools. Now, in addition to that, on April 15 they announced a $10,000,000 program of grants to the National Fund, which is a separate appropriation.

"The appropriation is intended to assist the National Fund for Medical Education in its efforts to strengthen financial support for medical schools throughout the United States, both public and private and develop new sources of such support.

"The maximum grant in any one year would be $2,000,000.

"In 1955 the National Fund raised approximately $2,147,000 in unearmarked funds for distribution to the nation's medical schools. If the Fund's receipts are of equal magnitude in 1956, the Fund would receive under Ford's Foundation grant 70 per cent of this amount, or $1,503,486. All contributions to the National Fund in excess of the 1955 total would be matched dollar for dollar subject to the annual maximum of $2,000,000.

"In succeeding years the Fund's receipts would be matched on a diminishing scale, but all receipts over the preceding year's total would be matched dollar for dollar, up to the $2,000,000 annual total.

"I think that is a wonderful thing because it will stimulate giving into the national fund and I think we must realize that every dollar that we contribute is probably going to be matched by a dollar from the Ford Foundation."

On motion of Drs. Bibler and Glock, the chairman of the Council was instructed to write a letter to the chairman and his Committee on Medical Education of the Indianapolis Medical Society, complimenting and commending them on their excellent work in behalf of the Medical Education Fund.

2. *Preceptorship and family care plan.* Dr. Bibler, chairman of the Sub-committee on Preceptorships, reported that he and Dr. Glenn Irwin of Indianapolis had visited the University of Pennsylvania on March 22 and asked that Dr. Irwin report on that meeting.

Dr. Irwin stated that the University of Pennsylvania had three programs:

(1) *The preceptor program,* an elective course, given between the junior and senior years, and ordinarily six weeks in duration, has been in operation for about five years. Approximately 25 to 30 out of a class of 125 members elect to take this course. These students are asked to do three things: (a) to keep a daily log of their activities while in this service; (b) to present a case report of some interesting problem that they have observed, and (c) at the end of the course they are asked for comments concerning the course and any ideas for improvement. The program is well received by those who are not married.

(2) *The family health advisory course,* also inaugurated about five years ago, is an elective course, with between 80 and 90 per cent of the students electing to take this course. Beginning in the freshman year of medical school, the course is supervised primarily by the Department of Public Health, the Social Service Division of the University and the Department of Psychiatry. Other departments, however, participate, because it takes

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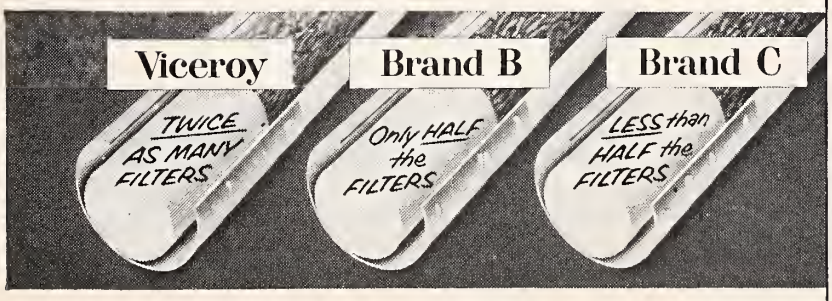


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many groups of advisors for the 100 or 110 students who take this course. Each student is assigned to a family in or near the Philadelphia area. The object is that he be an advisor rather than actually serve as this family's physician, to familiarize him with family problems, and to give him opportunity to observe the personal physician's management of this family. It also gives the student some idea of what perhaps he may be interested in eventually so far as his own career is concerned.

(3) *The General Practice Society or Fraternity.* The University of Pennsylvania has a number of students' societies or fraternities, not social necessarily, but professional, such as a Surgical Society, a Medical Society, and a General Practice Society. These societies have monthly meetings in to which they call certain outstanding practitioners in Pennsylvania or from elsewhere, their traveling expenses being paid from a fund which the dean collects from the students at $5.00 per student. The students are very enthusiastic about these societies.

Dr. Glock announced that his Committee on Medical Education and Licensure would meet on Wednesday, May 2, 1956, and invited Dr. Irwin and Dr. Bibler to attend that meeting and tell his committee about the Pennsylvania preceptorship plan.

Dr. Dudding said that the annual Junior-Senior Day was held on April 21. "We had quite a lot of conversation following that, and from the questions the juniors and seniors put to the members of the committee and the other physicians there, there undoubtedly is some drastic need for this type of program, as they feel that there is something missing in a correlative way."

It was taken by consent that the report of the Preceptorship Committee should be given to the Committee on Medical Education and Licensure, and the Committee on Medical Education later should refer it back to the Council.

3. "*Code for Autopsy Procedures.*" At the January 15, 1956, meeting of the Council this matter was referred to the Council Reference Committee on Public Health, composed of Drs. Dudding, Miller and Hammond. Dr. Dudding said "As an overall thing if the pathologists can supply enough pathologists I think that this program should be accepted. It is just good general procedure and I don't think basically that anybody found anything wrong with it. It is the type of thing that probably would encourage and get around some objections that some people have to autopsies."

On motion of Drs. Dudding and Miller, the Council accepted this code.

4. *Medical Education.* Dr. Glock, chairman of the Committee on Medical Education and Licensure, reported that his committee had met with the dean of the medical school with the following results:

(1) The dean approved having a voluntary program set up by the general practitioner group, and he is willing to accept that any time. He feels that each department should govern its own department but stated that he would be happy to have any of the general practitioners who have a special interest in any given field contact his office and he would consider those who are qualified to assist within the several departments of the medical school.

(2) It is the feeling of the Medical Education Committee that possibly an extern program throughout the state might fit in better than a preceptor system; the committee will have a report on this within the next few months, or at least by the time of the state meeting. Inasmuch as the majority of students in the medical school are married, in many instances it is not possible for them to leave Indianapolis to accept either an externship or a preceptorship. Also, Indianapolis hospitals pay an extern $250.00 to $300.00 a month whereas the hospitals out in the state cannot pay that much.

(3) The dean is unwilling to set up a Department of General Practice to allocate extra hours in the regular framework of their courses, but he is perfectly willing to set up a Department of General Practice from the standpoint of an advisory committee; he suggested that they could set up time aside from the regular hours that they now have; those would be evening courses.

Following discussion by Drs. Dudding, Glock, Bibler, Irwin and Denny, on motion of Dr. Miller, seconded by several, the Council referred this subject back to the Medical Education Committee for further study.

5. *Veterans Fee Schedule.* Dr. James W. Crain, chairman of the Committee on Veterans Affairs, submitted for approval the veterans fee schedule as revised by his committee after studying the schedules of Illinois, Kentucky, Ohio and Michigan, and also the Blue Cross-Blue Shield schedule, and after consulting with the clinical pathologists and the roentgenologists and getting their unofficial opinions as to what their fee schedules should be.

"We hope we have made a fair schedule. If we understand that this is to be considered, presently at least, as a maximum fee schedule for the entire state, that communities in which the usual fee for any procedure is lower than the fee stated in this schedule, the Veterans Administration reserves the right of paying the usual and customary fee that exists in that community. Whether or not that is as it should be is a matter for Council decision and then instruction to your representatives who will have to discuss this schedule with the Veterans Administration in Washington.

"The only change that we made that I think is of particular significance—I call attention to this one example to prove that we did try to make a

fair schedule out of it—is item 0023, 'Charge for mileage one way for day or night visit, all mileage over 2 miles from home or office in addition to appropriate fee . . . $0.75.' We did that in an effort to make a more equitable schedule for you gentlemen practicing in large centers where some calls will run 6 or 8 miles, and we thought you should be paid a mileage fee there as well as the man in a rural district who makes a call of the same distance.

"At the last Council meeting I told you that I would present this fee schedule to the Liaison Committee and attempt to get their approval. At the last meeting of the Liaison Committee a motion was made by Dr. Booher, as a representative of the American Legion, as follows:

> 'We are very willing to go along with the increases suggested except in those cases where the increases are greater than those granted to the states bordering on Indiana, inasmuch as we feel that the care of the veteran in this state should be equal to but not to exceed the amount paid for similar care in contiguous states. The maker of the motion accepts Dr. Sutton's suggestion that if these fees are revised annually by contiguous states, the Indiana State Medical Association should revise accordingly.'"

Discussed by Drs. Bibler, Dudding, Owsley, Crain and Miller.

On motion of Drs. Ross and Dodds, the Council approved the fee schedule and authorized the Veterans Committee to negotiate with the Veterans Administration on the basis of the fee schedule presented, and instructed the committee to get started earlier next year in the revision of the contract.

6. *Selection of directors at large for Board of Mutual Medical Insurance, Inc.* Dr. Bibler, chairman of the Council Reference Committee on Insurance, reported that his committee had met and had discussed the question of nominees for physician members of the Blue Shield Board of Directors. "In addition to the district representatives who are elected by the Council on nomination made by the respective councilor districts from which the member is to be selected, there are five members at large on the Board of Directors: In 1955 Dr. Dodds was re-nominated, and in 1956 Dr. Howard was re-nominated by the Executive Committee, and these reports of the Executive Committee have been accepted by the Council. Now in reading the resolution passed by the House of Delegates in October, 1954, I find there is no provision made for the selection of these members at large, and my committee would like to offer this recommendation:

> "That the members at large of the Board of Directors of Mutual Medical Insurance, Inc., shall be nominated by the Indiana State Medical Association Council at the January meeting of each year and that each member shall be limited to two consecutive terms.

"The purpose of this is to make it so that all members of the Board can be replaced when their terms expire, that is, each year some member's term expires, and then at the first meeting of the year, the January meeting, a man may be selected for this membership at large by this Council."

Following discussion by Mr. Stump, on motion of Drs. Bibler and Glock, the Council recommended that this matter be presented before the House of Delegates at the October meeting.

7. *Increase in AMA membership dues.* The secretary stated that in view of the fact that the Board of Directors of the AMA may recommend at the June AMA meeting that dues be increased, the delegates would like to know the attitude of the Council toward such a proposal. At the last session of the AMA, a specific recommendation was made that a part of such an increase be used for the Medical Education Foundation Fund.

Discussed by Drs. Glock, Bibler, Dudding, Ross and Miller. On motion of Drs. Miller and Bibler, the delegates are to be instructed to vote against any increase in AMA dues inasmuch as the Council is opposed to any raise in dues without further knowledge as to what the increase will be used for.

1956 ANNUAL SESSION, INDIANAPOLIS, OCTOBER 16-18, 1956

1. *Entertainment program.* Dr. James M. Leffel, chairman of the Committee on Convention Arrangements, reported that the plans for entertainment are progressing satisfactorily, and outlined briefly what these plans are.

Following Dr. Glock's discussion concerning the awarding of prizes for the trap shoot and golf tournament, the suggestion was offered that door prizes be given at the banquet, and Dr. Leffel agreed to give this idea some consideration.

2. *Instructional courses.* Dr. Bibler reported that the Indiana Academy of General Practice had passed a resolution expressing the hope that these courses would be continued. If they are continued the Academy will grant credit for them, as in the past. On motion of Dr. Ross, duly seconded, the Council approved continuation of the instructional courses during the 1956 annual session.

NEW BUSINESS

1. *Remission of state dues.* On motion of Dr. Ross, duly seconded, the Council voted to remit the state dues of one member each in the Daviess-Martin, Marion, and St. Joseph County Medical Societies, all of whom have retired due to illness.

2. *North Central District Blood Bank Clearing House.* Dr. Jene R. Bennett, Indiana's representative, spoke on the operation of the North Central District Blood Bank Clearing House, a medical organization, which has been in existence since 1954, concerned with so-called clearing of blood

units. The organization now includes 13 states, extending from Ohio to North and South Dakota, Nebraska, and south to Kentucky and Missouri, and includes Michigan and Wisconsin, the states in the general area of Indiana.

"Briefly, the organization is set up to serve the public, and the doctor, the idea being that in this day of increased use of blood too often the patient and the donor are separated by many miles and therefore it is inconvenient, or in fact impossible, for the donor to provide blood for the hospitalized patient. The North Central District Blood Bank Clearing House was organized as one of five clearing houses which will work together essentially as bookkeeping offices to keep a record of transfusions which are given in one part of the country and replaced by donors in another part of the country. Then at the end of each month these records are pooled and an attempt is made to cancel out these debts, thus avoiding the shipping of blood and the payment of replacement fees in cash."

Dr. Bennett presented a record of the number of transactions of the clearing house, showing that the work of the clearing house is steadily growing. The clearing house is operated on the basis of a fee of fifty cents for each unit of blood which is cleared through the office, and the income has not been sufficient to cover the expense of operating the clearing house, Dr. Bennett explained.

On motion of Drs. Glock and Miller, following discussion by Drs. Ross and Paris, Dr. Bennett's request for a loan of $1,000.00 without interest was to be referred to a committee, which is to report back to the Council at its next meeting.

3. *Matters referred to Council by Executive Committee.*

a. *Endorsement of podiatrists as members of the staffs of county hospitals.* The secretary said that this question had arisen due to the fact that three county medical societies had been circularized regarding this matter.

Dr. Owsley moved that the Council should not recommend that podiatrists be included as staff members of hospitals, since staff membership implies membership in the medical profession, but that the Council recommend that where patients desire the services of podiatrists in hospitals, podiatrists be permitted to perform such services upon the authorization therefor of the physician in charge of the patient, and that the matter of podiatrists' services be under the jurisdiction of the physician in charge of the patient. Motion seconded by Dr. Dudding and carried.

b. The following resolution adopted by the Floyd County Medical Society in reply to resolution of Local 23, UAW-CIO, was discussed by Drs. Paris, Vye, Dudding, Owsley, Kennedy, Bibler and Glock:

The Committee on Industrial Health, presents the following in reply to a resolution of Local 23 UAW-CIO, Indianapolis, Indiana, and recommends the adoption of the following Resolution by the Floyd County Medical Society.

WHEREAS: The premise set forth in paragraph 1 and 2 of Resolution of Local 23 UAW-CIO to-wit: the master schedule of indemnities set forth by the Blue Shield was established after numerous, prolonged and detailed consultations to determine what fees specific types of operations could be performed for and,

WHEREAS: It was the considered judgment and opinion of Blue Cross representatives, Labor Leaders and various laymen that this schedule of indemnities allowed under the plan would represent full payment for all types of surgery specified therein to the operating surgeon, is deemed by this society in error in that it is our belief that Blue Cross and Blue Shield never stated or implied that the schedule of indemnities in their plan would represent full payment for any or all types of surgery specified therein, and,

WHEREAS: The statement in paragraph 3 of the Resolution of CIO #23 UAW to the effect that it has been their unfortunate experience that this plan has come to serve more and more as the mere base upon which the total fees of the vast majority of surgeons are calculated and enhances their opinion that the insured is financially able to pay more and the approach in the determination of the fee has seemingly become one of charging whatever the traffic will bear with less concern to reason, equity and consideration is by this society deemed in error. It is common knowledge in this society and community that insurance indemnities are not used as a mere base for charging a total fee of whatever the traffic will bear and in no case is the true practice of members of the Floyd County Medical Society to charge a higher fee to any patient because he carries any type of indemnity plan and,

WHEREAS: It is not the opinion of this Society that as stated in paragraph 4 of Resolution of Local 23 UAW-CIO, Indianapolis to the effect that this condition, fact and reality has forced the union to seek expert and far reaching advice on this matter in a sincere effort to promote and protect the welfare of our membership and their families because it is their considered opinion that increasing allowances provided for in the schedule would only lend incentive to the levy of higher surgical fees rather than to solve the problem for which relief and redress is sought and for which reason it is resolved in resolution of Local 23 UAW-CIO to go on record as favoring the establishment of a central medical clinic in Indianapolis and dedicate itself to pursue every advisable manner in which to make this project a reality for their membership and their families that they enjoy the peace of mind afforded by the knowledge that their loved ones have complete coverage in any misfortune where medical attention and surgery is required at fees established through reason, fairness, and honest consideration, be it therefore

RESOLVED: By the Floyd County Medical Society that such centers are not conducive to good medical practices, patient care, or the future of the practice of medicine and that that impetus for the establishment of such centers comes partly from the failure to provide coverage for all medical service desired and partly from the failure of some physicians to relate their charges to the payments provided by insurance plans, be it further

RESOLVED: That the members of the Floyd County Medical Society express their willingness to enter into an agreement to treat hourly rated employees of their community and their families for medical and surgical conditions on the basis of an average schedule of realistic fees and to cooperate with Blue Shield and all other health insurance underwriters in offering to industrial and other groups a schedule of fees more nearly meeting the actual fees charged for medical care and broadening the scope of coverage to more nearly meet all, not part, of the medical requirements of the insured persons and since it has been the good experience of the employer and patient employee and physician and surgeon that such a goal is fairly well satisfied by the indemnity schedule now in force between the Colgate Company and the Metropolitan Plan based on New Jersey schedule, and be it further

RESOLVED: That the Blue Cross-Blue Shield give consideration to revision of their schedule which would thereby make a practical certainty the desires set forth in the resolution of Local 23—UAW-CIO and the understood desire of employer and employee patient, and be it finally

RESOLVED: That copies of this resolution be presented to the Indiana State Medical Association for action.

This is a true copy—

Daniel H. Cannon, M.D., Secretary,
Floyd County Medical Society.

RESOLUTION

No Council action was taken on the above resolution. The chairman suggested that since there are so many diverse questions regarding this matter, it might be advisable for the Insurance Committee of the Council to study all of the facets of it and inform the Council fully on it.

c. *Fee schedule.* Dr. Denny read the following letter received from the Wells County Medical Society:

"The Wells County Medical Society has appointed a committee headed by Dr. T. O. Dorrance to establish a fee schedule such as has been requested by the Indiana State Medical Association. He and his committee have been working on this for approximately two months. At our January meeting, on January 16th, it was found that an agreement could not be reached among the members as to what a proper fee schedule should be.

"I have been requested to write to your headquarters by the Wells County Society and ask that if possible we be instructed how specific and how extensive this fee schedule should be. As soon as this is found out the Wells County Society will go ahead with their attempt to set up this schedule.

"The Wells County Society is most anxious to cooperate in establishing this schedule and any information will be appreciated."

Following discussion by Drs. Dudding, Glock, Owsley, Dodds, Wilder, Sicks and Kennedy, the chairman read the following letter from the Bendix Corporation of South Bend, addressed to Blue Cross Hospital Service:

"We have received a request from the UAW-CIO that the Corporation give consideration to the purchase of benefits similar to those offered in California by the Kaiser Permanente Comprehensive Hospital and Medical Care Plan. At the moment the Union has suggested that we investigate this program which we understand is available in Southern California with the idea that we would replace the present Blue Cross benefits for employees at North Hollywood with the comprehensive plan. We realize that this comprehensive program is not affiliated with Blue Cross but it has occurred to us that you might be able to secure complete information on the benefits, cost, etc., from California for us.

"Any information you may be able to secure relative to the above will be greatly appreciated."

Further discussed by Dr. Glock, Mr. Stump, and Dr. Owsley.

On motion of Drs. Crowder, seconded by several, Dr. Glock was delegated to go to Wells County and try to settle this situation.

d. *Employees' retirement plan.* Dr. Sicks reported that the Board, consisting of Drs. Olson, Denny and Sicks, had carried out the instructions of the Council regarding the employees' retirement plan, and with the assistance of the legal counsel and the advice of the Executive Committee, the indenture had been drawn up and approved, and it is now submitted to the Internal Revenue Department and to the New England Mutual Insurance Company for their approval.

4. *Nominations for Editorial Board.* This matter was referred to the Council Journal Committee, consisting of Drs. Topping, chairman, Owsley and Ross, for report back to the July Council meeting.

5. *AMA office for Indiana physician.* On motion of Drs. Bibler and Dudding the Council went on record as endorsing and supporting any member from Indiana who may be nominated for any high office in the AMA, and the delegates to the AMA are to be so advised.

6. *Advertising contract of* THE JOURNAL. A new, nonprofit corporation, the State Medical Journal Advertising Bureau, Inc., has been formed to perform the function of the old State Journal Advertising Bureau. Mr. Hollowell, attorney for the Indiana State Medical Association, who had studied the contract, said that the new corporation will continue to serve state journals much in the same way as the old bureau did in the past, on a cooperative basis. The contract of the corporation allows 13 per cent of the receipts for operating expenses and semi-annually the Bureau will com-

pute its actual operating expenses and remit to the Journals any excess in the working fund.

On motion of Drs. Dudding and Ross, the Council authorized the signing of the contract with the State Medical Journal Advertising Bureau, Inc.

7. *Summer meeting of Council.* By consent, the next meeting of the Council will be held on Sunday, July 29, 1956, at the Indiana University Student Union Building, Indianapolis.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

April 28, 1956

Roll call showed the following present: James W. Denny, M.D., chairman; E. H. Clauser, M.D.; W. U. Kennedy, M.D.; Kenneth L. Olson, M.D.; O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Robert Hollowell, attorney; Robert J. Amick and Kenneth W. Bush, field secretaries; James A. Waggener, executive secretary.

Membership Report

Number of members April 27, 1956	3,936*
Number of members April 27, 1955	3,781
Gain over last year	155
Number of members December 31, 1955	3,975

* Includes
89 in military service (gratis)
109—$10.00 members (residents and interns)
287—senior members
65—members, dues remitted by Council
1—honorary member

Number who have paid AMA dues:	
April, 1956	3,359**
April, 1955	3,210
Gain	149

** Includes 463 exempt members (gratis)

Headquarters Office

The field secretaries gave a report on their activities during the past month, discussing county society reaction toward the science fair proposal and fee schedules.

The secretary reported that Room No. 1019 was obtainable, as was the space presently occupied by the Indianapolis Medical Society. A letter from the Indianapolis Medical Society regarding their willingness to vacate their present space and move to the room formerly occupied by THE JOURNAL was approved on motion of Drs. Kennedy and Sicks.

The secretary reported on the recent A. M. A. sponsored legal conference, calling especial attention to the discussion of the anti-trust procedures. Upon motion of Drs. Olson and Kennedy the legal counsel was instructed to prepare proper resolutions for use by county societies in adopting certain actions.

Treasurer's Office

The treasurer gave a report on the cash balance, and on motion of Drs. Olson and Clauser, he was instructed to invest additional funds in government bonds, the amount to be left to his decision.

Statements of Receipts and Expenditures for March for the Association and THE JOURNAL were approved.

Legislative Matters

National. Report on national legislative matters was accepted by consent.

Organization Matters

Report on the veterans fee schedule was made. No action was taken inasmuch as it is to be discussed by the Council at its next meeting.

Letter from Blue Shield was read in which a copy of a letter from the Bendix Aviation Corporation was attached. This was referred to the Council.

Letter and resolution from the Medical Society of New Jersey, seeking support of Indiana delegates in behalf of a candidate for president-elect of the American Medical Association, were read. A copy of this resolution is to be sent to the delegates without recommendation.

A copy of the recent statement by the California Medical Association on the relationship of fee values was given to the committee for its information.

A report from Dr. Jene R. Bennett, Indiana representative on the North Central District Blood Bank Clearing House, was referred to the Council.

Renewal of the subscription to the WASHINGTON REPORT ON THE MEDICAL SCIENCES at $55.00 per year for two copies weekly was approved on motion of Drs. Clauser and Olson.

It was taken by consent that correspondence with the State Medical Postgraduate Association be ordered filed.

The secretary reported that the matter referred to the Committee on Cancer had not yet been reported on by that committee.

The copy of the action of the Tippecanoe County Medical Society was read, and upon motion of Drs. Olson and Kennedy the secretary was asked to write a letter to Dr. Wendell Stover, chairman of the A. M. A. Committee, to investigate the operation of the Joint Commission on Accreditation of Hospitals, requesting that the authority of physician heads of hospital departments be clearly defined and that they be informed of any new rules which might be adopted.

A resolution from the Floyd County Medical Society regarding coroners ordering autopsies was

read and by consent it was agreed that the attorney should prepare a reply to the county society.

The contract for chartered air service from the Purdue Aeronautics Corporation for transporting winners of regional science fairs to the National Science Fair was approved and ordered signed on motion of Drs. Olson and Kennedy.

The committee voted to ask Dr. Ralph Eades and Dr. Earl Mericle to accompany these winners to the National Science Fair.

The indenture for the employees' retirement plan was reported back to the committee, and upon motion of Drs. Clauser and Kennedy the report of the Board of Trustees was accepted and the president and secretary and the Board of Trustees were authorized to sign the indenture.

A letter from Drs. Robert H. Rang and Hugh S. Ramsey was presented to the committee for its information.

A letter from the Indianapolis Medical Assistants' group, requesting approval of the state association of their effort to organize a medical assistants' group on a statewide basis and submitting a constitution and bylaws, was referred to the committee, and the attorneys discussed the wording of the bylaws in comparison with that of some other states.

Upon motion of Drs. Clauser and Olson the committee instructed the attorneys to prepare a standard bylaws as discussed by the committee and to notify the medical assistants' group that the State Medical Association would approve the organization of a statewide medical assistants' group and to inform them that the Executive Committee of the State Medical Association would officially constitute the advisory committee to such state organization.

There being no further business the committee adjourned to meet again at 5:30 p.m., Tuesday, May 22, 1956, in the Student Union Building, Indianapolis.

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News from the County Societies

Seventeen members of **Clark County Medical Society** attended an evening meeting April 17 in the Clark County Memorial Hospital in Jeffersonville. "Surgery" was the subject of the scientific discussion. A short business meeting was held during which a total fee schedule was discussed.

Dr. J. G. Weinbaum, Terre Haute, gave a paper on "Blood Banks" at the March 20 meeting of **Clay County Medical Society** in the Brazil Elks Club. Following his talk it was voted to establish a blood bank at the Clay County hospital.

The ISMA field secretary was present and reported on current projects and legislation.

Twelve members attended the dinner meeting.

Dubois County Medical Society members met April 12 in the Mullis Tourist Home at Ferdinand for a dinner meeting with members of the Woman's Auxiliary as guests.

No scientific program was planned. Following reports by the ISMA field representative and a representative of Blue Shield, there was general discussion of fee schedules, legislation and several local matters.

Members of **Fountain-Warren County Medical Society** and their wives were entertained April 5 in the home of Dr. Emmett C. Pierce, Attica. An Italian dinner had been prepared by Dr. and Mrs. Pierce and Dr. and Mrs. P. R. Petrich. Ten members and their guests and Dr. and Mrs. Joseph McKinley, Lafayette, special guests, were present. The next regular meeting of the society was scheduled for May 3 in the Attica Hotel, Attica.

Dr. William C. Fisher, Evansville, was the guest speaker for the **Gibson County Medical Society** on April 11 at a dinner meeting in the Emerson Hotel, Princeton. He spoke on "Management of Head Injuries".

During the business meeting the 12 members made plans to promote Medical Education Week through the city government, local newspapers and radio stations; discussed their completed fee schedule; went over local hospital problems; and heard a report from the ISMA field secretary.

Election of additional department heads, resolutions concerning public health and mass immunization programs comprised the action taken at a business meeting of **Greene County Medical Society** in the Freeman Greene County Hospital, Linton, April 12. Twelve members attended the evening meeting.

"Cyclaine Anesthesia" was explained in a medical film shown to members of **Hancock County Medical Society** April 23.

Sixteen members of the society attended a dinner meeting in Hancock County Memorial

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Hospital, Greenfield, and later discussed the Blue Cross preferred plan.

Kosciusko County Medical Society met March 20 in Murphy Medical Center, Warsaw, where they entertained their wives at a social hour and dinner.

At a business session later the society went on record concerning procedure in connection with the polio inoculations, setting a uniform fee for all shots, but making ample provision to protect children from families unable to pay.

Kenneth W. Bush, ISMA field secretary, then discussed the importance of fully understanding all provisions of the social security amendments embodied in H.R. 7225 and the reasons for opposing it; talked of the Medical Defense fund and its purpose, the tape recording loan library, and concluded his talk with a demonstration of the use of a recording machine, playing two recent scientific recordings.

Auxiliary members present outlined plans to promote Medical Education Week.

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The March 15 meeting of **LaPorte County Medical Society** was held in the Spaulding Hotel, Michigan City, with 40 members present. The meeting was devoted to business affairs of the society. Dr. G. O. Larson, LaPorte, spoke on H.R. 7225; the Committee on School Health recommended that the society follow the recommendations of the American Academy of Pediatrics pertaining to an immunization policy; and the society sustained the opinion of the House of Delegates at the October 1955 ISMA meeting in regard to mass immunizations.

On April 19 the LaPorte County society held a dinner meeting in the Norman M. Beatty Memorial Hospital at Westville. Dr. Margaret E. Morgan, Commissioner of Mental Health, presented a report on the status of mental illness in Indiana and in the United States, stressing the need for more psychiatrists, more mental hospitals and more research.

Sixty-five members of the society, the Auxiliary and several special guests were present. Special music was provided by students from Berrien Springs College.

Dinner was served to members of **Madison County Medical Society** at the Anderson Country Club on March 19. Dr. James H. Stygall, Indianapolis, was the guest speaker. He talked on tuberculosis, outlining some recent developments in treatment.

Dr. Merrill P. Benoit, secretary of the society, discussed H.R. 7225 and reviewed the County Society Officers Conference.

Several matters of local importance were discussed.

Dr. Owen H. Wangensteen, Minneapolis surgeon, was the guest speaker at the April 24 meeting of **Indianapolis Medical Society** in White Cross Guild auditorium, Methodist Hospital. His topic was "The Extended Operation for Alimentary Tract Cancer." He was introduced by Dr. Harris B. Schumacker.

Eleven physicians made application for membership in the society and the following were admitted to membership: Drs. Robert E. Bakemeier, Gabra S. Gachaw, John Melin, Robert McDougal and John H. Kneidel.

Dr. James H. Gosman reported on the 1955-56 WISH-TV series, thanking the members for



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their help. The last of the current series of programs was presented on April 25.

Dr. John R. Swan, read a resolution memorializing Dr. Carl B. Sputh, Sr., who died on April 8. The committee to draw up the resolution included Dr. Swan, chairman, Dr. C. H. McCaskey and Dr. Ben Moore.

Members of **Morgan County Medical Society** and their Auxiliary attended a dinner meeting April 8 in the Artesian Mineral Springs Sanitarium in Martinsville.

At the business meeting which followed Robert J. Amick, ISMA field secretary, reported on the American Medical Education Foundation, fee schedules of other states, action on legislation in Congress and several other current topics of interest to the medical profession. The field secretary and members discussed each subject to clarify positions taken by ISMA and AMA on a number of somewhat controversial matters.

Sixteen members and guests attended the meeting.

Eight members of **Orange County Medical Society** attended a dinner meeting in the French-Lick Sheraton Hotel April 1.

Following dinner a business meeting was held with R. J. Amick, field secretary for ISMA, reporting on pending legislation, fee schedules, science fairs, the Salk vaccine program, the observance of Medical Education Week, and services of ISMA. The remainder of the meeting was devoted to a general discussion of local problems.

Putnam County Medical Society members voted to send $20 per member to the American Medical Education Fund and also to make individual contributions at a meeting on April 13 in the DePauw Union building, Greencastle. A report on many current medical affairs was presented by the ISMA field secretary.

Dr. Alexander T. Ross, Indiana University Medical Center, was the guest speaker for the scientific program. He talked on "Neurological Causes for Difficulty in Walking."

Fourteen members attended the dinner meeting.

Plans for conducting a Health Day program were outlined by K. W. Bush, ISMA field secretary, for members of the **Randolph County Medical Society** March 12 at a meeting in Randolph County Hospital. Recordings of the "Rural Health Day" program of the Committee on Rural Health of the Indiana State Medical Association were played and a report made on the successful Bartholomew-Brown County Medical Society Health Day program.

Several other projects were discussed briefly.

Dr. J. P. Pratt, Detroit, a gynecologist, presented a paper on "Care of the Terminal Patient" at a dinner meeting of **Tippecanoe County Medical Society** in "The Trails" near Lafayette April 10. The paper was well received and was recorded for the ISMA recording library.

At the business meeting following Dr. Pratt's talk, the society discussed a hospital staff meeting, a plan for emergency medical service, and heard a report by Dr. K. E. Neumann on the County Society Officers' Conference.

The ISMA field secretary discussed several routine matters including the necessity of submitting any proposed resolutions for the House of Delegates at an early date in the summer.

A business meeting of the **Vigo County Medical Society** was held in Union Hospital, Terre Haute, April 10 with 21 members present. George W. Sims of the State Fire Marshal's office reported on results of his recent inspection of Vigo county nursing homes. A report was made by the ISMA field secretary on several matters at state and national levels. General discussion of the several topics followed.

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